Social inequality and the diagnosis of paranoia

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Abstract

One of the obstacles to understanding the links between social inequality and mental health distress is the reliance on heterogeneous diagnostic categories. In this paper, it is argued that a solution to this problem is to focus on more homogenous experiences of distress.   This paper focuses on one particular form of distress – paranoia. The relationship between social inequality and paranoia is then examined, focusing on two aspects. Firstly, it is argued that social inequality might affect the experience of paranoia itself since the experience of the surveillance encountered in the everyday use of public space may vary depending on one's location in social categories like gender, 'race' and culture and class (these social categories are, of course, themselves stratified by social inequality). Secondly, mental health service users' locations in these categories may influence the way that the plausibility of ostensibly paranoid claims are evaluated by mental health professionals. Within the discussion of each category, links are drawn between community and clinical samples to understand how the experience of paranoia may be influenced by these social categories. The paper concludes implications with implications for research and policy.

Introduction

<u>Three problems in investigating social inequality and mental health</u>

The role of social inequality in the development of mental health distress has come to the fore again recently in debates concerning Wilkinson and Pickett's (2009) *Spirit Level*. By social inequality I mean to refer to the ways in which groups of people have differential access both to economic resources (e.g. income, the labour market etc) and a range of services like education, housing and so on. Social inequality exerts its effects through socially-defined categories like gender, 'race'1 and culture and class such that for example, in many industrialised societies, women, black people and people from working class backgrounds have less access to economic and other resources as a result of their social status. Indeed, many people located in these categories may experience discrimination – for example sexism, racism and classism.

Wilkinson and Pickett (2009) make the case that mental health, like many other social problems, is correlated with the size of the gap between the richest and the poorest in many countries (see also Pickett and Wilkinson, 2010). It is important to conduct more research on the links between inequality and mental distress and on public health interventions to address these links. However, a number of problems have often obstructed progress in this area.

Firstly, as Rogers and Pilgrim (2003) point out, one of the problems with psychiatric epidemiology is the uncritical use of contested psychiatric diagnostic categories like

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1 Given the consistent evidence against the notion of genetically different races (Jones, 2000), the term is placed in inverted commas at its first appearance here and it is employed only because it is in common usage.

'schizophrenia', given their much discussed problems of heterogeneity and co-morbidity (as well as other problems of validity and reliability – Bentall, 2004; Boyle, 2002; Kirk and Kutchins, 1992; Kutchins and Kirk, 1999). One solution is to focus on more homogenous experiences (or 'symptoms' within a medical framework). This can be especially helpful when we appreciate that a particular experience like paranoia can be found in many different diagnostic categories – Mirowsky and Ross's (2003) cluster analysis, based on community samples, shows that experiences of distress cluster but not in a manner consistent with current diagnostic classificatory systems.

A second problem is that mental health researchers have often focused only on clinical rather than general community samples, thus limiting the claims that can be made about the effects of inequality. This neglect appears to be based on the assumption that there are qualitative differences between these sample groups that make generalisation problematic. Although, for example within the field of psychosis, researchers like Strauss (1969) have argued for a long time that differences are quantitative rather than qualitative, a substantial body of empirical research now confirms this. Indeed community surveys regularly indicate that substantial minorities of the general population report particular psychosis-like experiences – thus Peters et al (2004), reported that the average endorsement frequency for the 21 item version of the well-validated *Peters et al Delusions Inventory* was 29.8% in their normal sample of 444 people.

A third problem is that debates about inequality and mental health have often been characterised by binary oppositions -- either/or formulations. Parker et al (1995), for example, note that differences in the rates of psychological distress in relation to the social categories of gender, class and race and culture are seen either as result of misdiagnosis (e.g. as a result of health professionals' prejudice based on gender,

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race, culture or class) or, as a result of people being treated in a discriminatory manner on the basis of these social categories. Instead there is a need to see both these factors as mutually influential – I will argue that the more appropriate formulation is a both/and one: thus both misdiagnosis and discrimination play a part in the production of distress.

In this article I aim to discuss research and scholarship relevant to conceptualising the links between social inequality and a particular form of distress -- the experience of paranoia. For the purposes of this paper I will draw on the definition of paranoia suggested by Cromby and Harper (2009: 335):

> Paranoia can be defined as a way of perceiving and relating to other people and to the world that is characterized by some degree of suspicion, mistrust or hostility. It is usually understood to exist on a continuum, so that degrees of paranoia inhabit many everyday social relations. When it reaches the level where a person may encounter psychiatry, paranoia is frequently characterized by complex, self-insulating conspiratorial belief systems, distorted perceptions and high levels of distress … paranoia [is] a socially and materially co-constituted mode of, or tendency within, embodied subjectivity. We understand it as a way of being in the world, manifested differentially according to changing social, cultural and material circumstances and the specifics of life trajectories.

By focusing on this relatively homogeneous experience I hope to avoid the first problem (of diagnostic categories). Because the focus here will be on the experience as it cuts across both the 'general' and 'clinical' populations -- rather than a particular diagnostic category – I hope to avoid the second problem (of only focusing on clinical samples). People develop more severe forms of distress whilst they are members of

the general population (Huppert, 2009). One way of understanding how people become severely distressed is to examine community samples and investigate distress that is similar in form but at a much less severe level. By studying the fears and anxieties of community samples we may gain some indication of the kinds of processes which may lead people to experience the much more pronounced levels of fear, anxiety and suspicion which characterise paranoia. In particular, by focusing on certain social groups or categories we can explore how discrimination against certain categories of person may play a role in the development of more severe distress.

To address the third problem noted above, I will argue that social inequality, mediated through dominant social categories like gender, race and culture and class can have a two-fold effect. Firstly it can affect the experience of mental health distress on people positioned in these categories. This might be seen through quantitative differences between people located in different social categories, illustrated, for example, by different prevalence rates of paranoia. However, this might also be seen in qualitative differences between people in different categories – in other words, even if there is no quantitative difference between groups, the 'same' experience might be experienced very differently. Secondly, these categories are stratified by social inequality (Mirowsky and Ross, 2003; Rogers and Pilgrim, 2003) and this may affect how distress is seen by others – an experience of paranoia for example, might signify very differently depending on which social group is exhibiting it. Thus assumptions about social categories might affect the judgements of health professionals as they diagnose, refer to other agencies and so on. For example, might a health professional's judgement of the plausibility of a service user's belief vary according to the belief-holder's location in these categories? In attempting to understand these twin effects of inequality I hope to avoid the limitations of previous dualistic accounts.

However, before we move on to discuss the effects of inequality, it is important to consider how assumptions about social categories might influence a professional's judgement of whether a person's account was plausible or paranoid.

Social inequality, social categories and health professionals' response to paranoia: Influences on their judgements

The notion that judgements about the plausibility of a person's beliefs might be influenced by their social context has received relatively little attention in the literature in recent years. The 1960s, however, saw a number of attempts to grapple with this issue. Lemert's (1962) study of paranoia focused on its interactional context in social situations, drawing on his earlier work. Scheff (1963) developed labelling theory and, in more recent work (Scheff, 1999) has responded to critics. Laing and Esterson (1964) attempted to apprehend the meaning of psychotic experiences by locating them in family dynamics. However, in the four decades since there has been relatively little research on why hearers of ostensibly deluded belief claims find them implausible – often, in the literature, it is simply taken for granted that it is self-evident.

Outside of the mental health arena, there has been some research and scholarship on what it is that makes accounts seem plausible. Writing about autobiographical narratives, Gergen (1994) has argued that there are cultural 'rules' by which narratives are judged. He has suggested that five 'critical ingredients of the well-formed' or 'intelligible narrative' (1994: 91) include: a valued endpoint (i.e. the 'point' of the story, usually a socially valued one); a selection of related events; which are presented in a temporal order; with causal linkages made between them; and 'demarcation signs' which enable the audience to distinguish between, for example,

fictional and factual accounts.   Within Discursive Psychology, similar rhetorical devices are seen as increasing the facticity of accounts (e.g. Edwards and Potter, 1992). Gergen notes how narratives following these rules can be quite persuasive in, for example, a courtroom context. Foress Bennett (1997) has made some interesting comments about plausibility, having found it a central concern in her analysis of rape testimonies in court cases. She suggests that:

[T]he plausibility of a story in itself is a function of its hearer's readiness to make sense of its organization at multiple levels: the plausibility of narrative relies on the symbiotic relation of text organization (schemas) and cultural assumptions about the way the world works

Foress Bennett (1997: 100)

Foress Bennett's reference here to 'cultural assumptions' draws attention to the possible influences on the judgement process. It is possible to trace a concern with this issue in the work of a number of researchers. For example, in a broader discussion of the intelligibility of mental distress, Ingleby (1982) has argued that whether we see the actions of another person as making sense will depend on judgements of plausibility which may vary according to how 'charitably inclined' (Ingleby, 1982: 133) we are towards them. Heise (1988), in his social constructionist critique of the concept of delusion, suggests that, in coming to make diagnoses, psychiatrists attempt to determine the 'social currency' of beliefs (Heise, 1988: 269). Simpson (1996), in her discussion of the social construction of beliefs about safety and danger, argues that the difference between ordinary fears and those considered unusual is the extent to which fears are socially warranted. More recently the cognitive therapist and researcher Morrison has made a similar point in arguing that though there are many similarities between 'anxious' and 'psychotic'

(mis)interpretations '[t]he main difference that appears to constitute the classification of such interpretations as psychotic seems to be their cultural unacceptability' (Morrison, 2001: 260). Surprisingly, though, how diagnosers assess this cultural unacceptability does not appear to have been a focus for researchers.

This short review indicates that, in recent years, there has tended to be a focus on the textual features which might influence judgements of plausibility, rather than the features of the person giving the account. However, might a diagnoser's assessment of the social currency of a belief be influenced by the belief-holder's social status – that is, their location in social categories like gender, race and culture and class? As Georgaca (2004) observes about her patient interviewee, Don: '[a]t the end of the day, however well Don argues his case in interactions within the ward, he cannot but argue it from the institutional position of a patient' (2004, p.22). Heise (1988) makes a similar point. It seems possible that hearers of accounts may be influenced by assumptions about social categories.

I have argued so far that there is a need to focus on a relatively homogeneous experience of distress (like paranoia) and to examine how social categories, stratified by social inequality exert an influence on the expectations of diagnosers. However it may also exert an influence how paranoia is experienced.

Social inequality, social categories and the experience of paranoia

A key aspect of the experience of paranoia is how people experience the gaze of others -- how they manage the everyday surveillance we encounter in public space, both formal (e.g. CCTV) and informal (e.g. engaging in 'people watching'). Within the field of criminology, Coleman and McCahill (2011) argue that such surveillance is

experienced differentially across different social groups with young people, women and girls and black people often experiencing increased state surveillance because of assumptions of deviance that reflect their differential social status. In relation to crime they note that young and black men are often of concern and, following the 11 September attacks in the US, Muslims have become a focus of surveillance by police and counter-terrorist agencies. Thus, if people in these social categories report experiences of heightened surveillance this may have a basis in reality.

Here, I will focus on three dominant social categories: gender; race and culture; and class. As I have already noted, these categories are stratified by inequality – they are axes along which social inequality may be experienced (Mirowsky and Ross, 2003; Rogers and Pilgrim, 2003). Of course, in focusing on these three social categories separately, I do not wish to imply either that they are static or homogenous nor do I wish to presume a particular mapping between social category and lived experience (Burman, Gowrisunkur and Sangha, 1998). Instead, this division is a pragmatic one, enabling us to focus in detail on particular forms of difference and inequality. Moreover, limitations of space mean that other categories (e.g. sexuality, disability, religious faith, educational status etc) could not be adequately examined here. This project is somewhat ambitious and runs the risk of superficiality but, I will argue, such a broad-ranging account is necessary to avoid the problems caused by focusing on particular social categories in isolation.

Within each of the following sections we will investigate how the experience of paranoia is reported in relation to that social category both within clinical and community samples. Then we will examine how assumptions about each social category may influence how the experience of paranoia is seen, for example by health professionals.

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The dual nature of the relationship between social categories and paranoia

Paranoia and the gendered construction of fear

Gender and the experience of paranoia

A recent survey of the UK general population suggested that men were more likely to report higher levels of paranoia (Johns et al., 2004) and an experimental study of participants from the UK general population noted that women reported less paranoia (Freeman, Pugh, Antley, Slater, Bebbington, Gittins, Dunn, Kuipers, Fowler and Garety, 2008). Nevertheless, it is also a position in which women can be placed – a US general population study reported that women were more likely to meet the criteria for paranoid personality disorder (Grant et al., 2004). Williams, Lee Trick and Troum (1981), for example, describe the diagnosis and treatment of 'the paranoid wife syndrome' which is a clearly gendered diagnostic category. However, although different prevalence rates give some indication, it is likely that the category of paranoia and associated fears signify differently for men and women particularly as they may experience public space differently (Brown, 1998). For example, women and girls have been much more exposed to stereotypical notions of femininity and to popular media which encourage a particular view of women's bodies (Bordo, 1993).

Brown (1998) studied women's experience of public space and everyday surveillance in the North East of England. She reported that, in both the daytime and evening time public space was used by twice as many men than women and thus the town centre was experienced as 'men's space'. Furthermore she noted that '45% of women had been "stared at"' and 38% had been "shouted after" by men in the 12 months preceding the survey, in ways which made them feel "uncomfortable"'

(p.212). As a result of her findings on the differences between the men's and women's reports she argued that:

> Men and women actually perceive, and react differently to, public space. Being seen, for women, is a condition of everyday life: their feelings of extreme visibility in public are created by masculine regulation of the public domain.

<div align="right">Brown (1998, p.218)</div>

Given the experiential force with which this visibility is felt, some feminist authors are vigilant about being termed paranoid simply for describing the effects of such surveillance. Thus Ussher (1991) argues that women 'continuously watch for their safety' since 'their sexuality is under constant surveillance' and she notes that 'this experience of surveillance is not based on paranoia' (p.265). Similarly, Sheffield (1992) writes about her experience visiting a launderette in the evening:

> I became terrified. I wanted to leave and find a laundromat that was busier, but my clothes were well into the wash-cycle, and besides, I felt I was being 'silly', 'paranoid'.

<div align="right">Sheffield (1992, p.61)</div>

Brown (1998) reported that the men in her community sample reported similar experiences to the women noted above but, generally, at much lower rates. In the next extract, Westwood (1990) discusses how British black men develop a strategy of being 'streetwise' in order to negotiate the dangers of city street-life:

All the men were wary of other parts of the city and especially the city late at

night. It was dangerous and they did not voluntarily walk alone in the city up

to and after midnight.

Westwood (1990, p.65)

The men's wariness may similarly be based on good evidence (and we will look at

the issue of racism in the next section) but, although it may simply reflect the authors'

orientations, it is interesting that these ostensibly similar descriptions are described in

slightly different ways. Westwood characterises such concerns as an aspect of being

'streetwise' and thus they are positively valorised -- in other words suspicion is seen

as plausible and warranted. On the other hand both Ussher's and Sheffield's

accounts suggest that women's fears are plausible but they also note the danger that

those fears may be read by others as paranoid. Interestingly, it has been feminist

scholars who appear to have been most sensitised to gendered surveillance. Given

that it appears to be men who report more paranoid experiences, predominate in

diagnostic categories like schizophrenia and are more likely to be referred to forensic

psychiatry services this is an important area to research further.

Gender and professional judgements of plausibility

As I have argued above, gender appears to influence the experience of paranoia.

However, do assumptions about gender influence how the plausibility of apparently

paranoid fears is assessed? In judging the reasonableness of fears there seems to

be an implicit comparison with what is presumed to be the norm – what Sampson

(1993) has termed the 'absent standard'. What might this absent standard consist

of? Hollway and Jefferson (1997) suggest that much of the literature on fear of crime assumes a rationally calculating individual who objectively assesses statistical risk and whose fear mirrors this assessment. Rationality is not a gender-free or culture-free concept and Gaines notes how 'Western psychiatric sciences habitually construct certain Western selves (male, adult, Euro-American, or European Protestant) as rational and others as irrational and prone to delusions or other mental dysfunctions' (1995, p.281).

How might these assumptions about social categories affect diagnosers' judgements of plausibility? A study by Rienzi and Scrams (1991) gives some indication. They asked male and female university students to assign gender to six descriptions of <u>DSM</u> personality disorders. They reported that men tended to be diagnosed as paranoid, anti-social and compulsive whilst women tended to receive diagnoses of histrionic and dependent personality disorders. They argued, on the basis of their study, that this occurred because these diagnoses mapped onto gender-specific role expectations and stereotypes. Thus within society in general, men are 'directed to be clever and aggressive but not antisocial, to be sophisticated and suspicious but not paranoid' (Rienzi and Scrams, 1991, p.978). Gender, of course, is not the only social category which can influence how paranoia is experienced or how it is seen by others and, so, we next turn to issues of race and culture.

<u>'Race' and the cultural context of paranoia</u>

'Race' and culture and the experience of paranoia

The DSM-IV definition of delusion notes that, to be a delusion, a belief should not be 'ordinarily accepted by other members of the person's culture or sub-culture' (APA,

2000, p.821). However, as Moor and Tucker (1979) have noted, references to 'culture' and 'sub-culture' in diagnostic criteria are ambiguous and there are no criteria to identify what the correct reference class is for a person (e.g. nationality, race, class, gender or neighbourhood, etc.). As Perkins and Repper (1996) point out, people belong not only to one community, but many: geographical; religious; political; sexual; philosophical and so on. Indeed, with the rise of the internet, it is now possible for geographically separated people to find others who share beliefs considered by some to be idiosyncratic (Bell, Maiden, Munoz-Solomando and Reddy, 2006). A further problem is that surveys of the general population generally report high levels of belief in supposedly irrational phenomena (Moore, 2005). Thus the absent standard against which supposedly deluded beliefs are compared may incorporate cultural assumptions that are inappropriate for many of those in Western societies too.

When apparent differences between ethnic groups are reported, how this is understood may reflect further implicit assumptions. Thus Westermeyer (1989) noted high prevalence rates of paranoid symptoms amongst Hmong refugees in the US but saw this as a sign that they had failed to 'acculturate' to the 'mainstream' rather than a failure by the local community to welcome them and embrace cultural diversity. Although, migration is stressful in itself and although refugees are often fleeing traumatic situations, another cause of paranoid feelings may the reception by the host community – for example, the nature of public debate about refugees, whether one's reasons for travel are believed, whether one can access work and accommodation and so on (Laban, Komproe, Gernaat and de Jong, 2008).

There is some evidence from the USA that African Americans score higher on a measure of paranoia compared to people from a non-Hispanic white background (Combs, Penn and Fenigstein, 2002). On the one hand, this kind of result can be

read as implying pathology or it can be understood as related to discrimination both perceived (Combs, Penn, Cassisi, Michael, Wood, Wanner et al., 2006) and actual (Read, 2004). As the African American family therapist Kenneth Hardy has put it '[w]hat is seen through one lens as psychological paranoia, in another can be seen as a logical result of discrimination and racism' (Hardy, 2001, p.54). This has led some workers to argue for the notion of a 'healthy cultural paranoia' which is 'an adaptive mechanism for coping with a life that is plagued by prejudice and discrimination' and which 'must be differentiated from paranoia as a functional illness' (Newhill, 1990, p.177) – a concept recognised by the American Psychological Association (1993).

We saw above how the experience of surveillance can be a gendered one. However, it is also influenced by race. Coleman and McCahill (2011) argue that '[o]ver the last 200 years, surveillance practices have fallen disproportionately on members of ethnic minority communities' (p.117). For example, analysis of Ministry of Justice figures for England and Wales between 2008-2009, revealed that black people were 26.6 times more likely to be stopped and searched by the police than white people whilst South Asian people were 6.3 times more likely to be stopped than white people (Townsend, 2010). Coleman and McCahill (2011) draw on Griffin's (1960) description of the 'hate stare' experienced by African Americans in the American South, arguing that post 9/11 the hate stare has returned. As we saw in the quote from Westwood (1990) above, minority ethnic communities are another group who may feel visible and under surveillance in public space. Interestingly, Boydell *et al* (2001) reported a higher prevalence of schizophrenia diagnoses among black people living in majority white areas in the UK compared with black people living in residential areas where the majority of people were black. This study has received more empirical support recently (Das-Munshi, Becares, Dewey, Stansfield and Prince, 2010) though the nature of a causal relationship remains unclear (lester, 2010). Whilst correlational,

findings like these suggest that more attention be paid to the experience of difference and visibility. It is, perhaps, no surprise that this experience of visibility is evidenced in mental health settings.

Whaley and Hall (2008) identify both race-related and racist content in the reported delusions and hallucinations of African American psychiatric patients. Sharon de Valda (1996), a black British mental health service user, comments 'as I lived in a white area people stared and I grew up paranoid and lonely' (p.5). She goes on to say:

> The doctors have labelled me as a 'PARANOID SCHIZOPHRENIC'. I don't accept the label. I must admit that I am confused and even 'paranoid' in some all-white company. Basically racism is a white problem...If I am sitting in a pub amongst all whites, I am aware they are staring and possibly making sly remarks. It is not imagination or paranoia. Far from it -- it is stark reality.

> de Valda (1996, p.5)

Despite the apparent plausibility of a black woman's fear of racism, there is a felt need to defend against an accusation that one is 'just imagining it' or being 'paranoid'. However, whether this is viewed as 'healthy paranoia' or a more pathological form will depend on the assumptions of the diagnoser since the diagnostic criteria have to be interpreted by the clinician.

How might assumptions about race and culture affect the assessment of the

plausibility of the fears of people located in this social category? An important issue

to address is the way in which issues of race and culture are either ignored in the

research literature or, if they are not, the concerns may be pathologised in some way.

Phoenix (1987) has argued that this present absence/pathologized presence of

issues of race and culture is an important influence which shapes the assumptions of

practitioners.

One of the few studies examining the assumptions of diagnosers in relation to race

and culture was a vignette study of American psychiatrists by Loring and Powell

(1988). They reported that black men tended to be identified as the most severely

disordered and were given a diagnosis of paranoid schizophrenic disorder and both

black men and women were more likely to be given a diagnosis of Paranoid

Personality Disorder than white people.

Gaines (1995) and others have argued that the absent standard against which

psychiatric subjects are compared is apparently culture-less -- but actually reflects

the absent standard of the white Euro-American Western male. Within mainstream

psychiatry, 'culture' stands for that which is other, foreign and exotic and concerns

about culture and race serve as proxies for issues relating to members of minority

ethnic groups rather than majority groups which are, by implication, seen as

homogenous. Kutchins and Kirk (1999) note that, within diagnostic manuals like the

DSM '[t]here is an implicit assumption that the clinician is from the dominant culture

and the client is a member of a minority group' (1999, p.233). Boyle (1997) argues

that, whilst attention to the cultural context of beliefs is increasingly recognised as

important for those from non-Western cultures, this analysis has not 'amounted to

any real change in the way we think about "delusions" and "hallucinations" in dominant western groups' (p.13). Indeed, psychiatrists Kingdon and Turkington (1994) have observed that there is 'a greater diversity of culture within western and other societies than often seems to be acknowledged in a mental health context' and that these are 'not determined by a separate language or skin colour' (p.23).

Gender, race and culture are forms of difference which are often visible but we turn next to a social category which, whilst potentially less visible, can still influence both the experience and diagnosis of paranoia.

Class, power and the credibility of delusional claims

Class and the experience of paranoia

Parker et al (1995) have noted that there has been a decrease in social scientists' interest in class in relation to mental health. Where it is discussed, they argue that it is seen as an individualised variable (e.g. as 'social class' or 'socio-economic status') rather than referring to a class of people or the exploitation of labour, alienation and oppression. Similarly, Read (2004) notes that there has been a decline in research on poverty and schizophrenia with researchers now preferring the more politically neutral term 'urbanicity'. However, as we have seen with both gender and culture, phenomenological studies suggest that surveillance characterises the experience of public space by working class people:

> … the people here [University] walk round and they're just looking, scanning
> all the time, yer can tell they're scoping for something all the time, you see it

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when they walk in a room, it's like the gays have a saying, they call it 'gay-dar', they have 'class-dar' or 'posh-dar' …

26 year old working class student participant cited in Charlesworth (2005, p.300)

As Charlesworth notes '[i]t is hardly surprising that individuals who are the most poorly endowed with the means to signify existence in relation to cues of income and status become socially phobic' (2005, p.311). Of course it would be wrong to suggest that paranoid positions are only adopted by the poor. For example, conspiratorial and paranoid rhetoric can be used by the politically powerful as was demonstrated by British Prime Minister Margaret Thatcher's reference to 'the enemy within' during the 1984 UK miners' strike (Wilenius, 2004). Moreover, people in these positions have the power to act on their beliefs, to influence media representation and so avoid being marginalised and pathologised.

Class can work in contradictory ways in relation to paranoia. Amongst diagnosers, there may be more tolerance for middle class people holding implausible beliefs where they may be seen as a sign of eccentricity as opposed to working class people where such beliefs might be seen as a sign of pathology, drawing on cultural assumptions of working class people being particularly vulnerable to the development of psychological distress (Blackman, 1996). However, if people are positioned structurally in certain ways such that they actually are relatively powerless then the adoption of a paranoid position might be an understandable way of trying to make sense of forces that are beyond one's control.   The cultural critic Fredric Jameson has argued that conspiratorial narratives may be 'the poor person's

cognitive mapping in the postmodern age' (1988: 356). In other words, such

narratives might solve a fundamental representational problem: how to picture an

unimaginable and increasingly technologically sophisticated global network that is so

vast that it cannot be 'encompassed by the natural and historically developed

categories of perception' (1992: 2).

Class and professional judgements of plausibility

If class can influence the experience of paranoia can assumptions about it also exert

an influence on judgements about the plausibility of the fears of the working class? It

is possible to elucidate class-related implicit assumptions relevant to paranoia.

Spitzer makes some of these assumptions explicit, thus 'normal people can give

reasons, can engage in a dialogue and can engage in the possibilities of doubt

etcetera, especially if we talk critically to them' (1995, p.325). These assumptions

about 'normal' beliefs -- lacking, it must be said, much basis in empirical evidence of

how people actually engage in talk about beliefs -- are characterised by the

possibility of intellectual debate and empirical investigation which evoke certain class

sensibilities implying an educated elite who engage in philosophical debate and are

prepared to provide evidence for statements of belief. In the same way that the

absent standard against which the supposedly paranoid subject is contrasted is seen

as a white Western man so it also appears to be classed.

Implications for research and practice

We have seen how social inequality may affect both how paranoia is experienced for people located in the social categories of gender, race and culture and class categories and may also affect – as a result of assumptions about those same categories (which are themselves stratified by social inequality) – how apparently paranoid fears are evaluated by others, for example health professionals.
In this section I will briefly outline some implications of this analysis for research and policy.

Research: The need to focus on experience and on diagnosis

I have argued that we can learn about the dual effects of social inequality by investigating the experiences both of the general public and of mental health service users in relation to particular experiences of psychological distress like paranoia. This area of research is under-developed and Pickett and Wilkinson's (2010) hypotheses for the correlation between mental health distress and social inequality require empirical investigation. As Cromby and Harper (2009) note 'social inequality is not uniform, does not impact upon people uniformly, and is not responded to or dealt with uniformly' (p.353) and our understanding of the causal pathways linking inequality and distress is incomplete.

Further research is needed to understand more fully the relationship between membership of a social category and the experience of paranoia -- for example, why might men be more likely to experience paranoia and how might this relate to the experience of men in the mental health and criminal justice systems? Moreover, are particular aspects of the content of paranoid beliefs related to social categories? In

order to address issues like these fully, however, it may be important to examine how socially-derived categories combine and influence each other in the experience of distress. Intersectionality may be a useful conceptual resource here and it has been utilized both within the context of general health (e.g. Mullings and Schulz, 2005; Warner and Brown, 2011) and mental health and psychotherapy (Burman, 2004).

Given the possibility that assumptions about social categories may influence judgements of the plausibility of ostensibly paranoid beliefs, there is a need for further study of the process of diagnosis, in particular, an examination of influences on professionals' judgements of plausibility. For example, studies of the reliability of psychiatric diagnosis do not investigate why two professionals might evaluate an apparently delusional claim differently – what might be the personal, interactional and institutional influences on such judgements? Moreover, given that such claims can be evaluated differently within current diagnostic criteria, mental health professionals need to acknowledge that judgments about beliefs are social and cultural rather than simply unproblematically objective.

Policy: Planning for trust

In recent years there has been more of a recognition of the links between inequality and distress (e.g. Friedli, 2009; Pickett and Wilkinson, 2010; Royal College of Psychiatrists, 2010). This paper has demonstrated how one's location in social categories like gender, race and culture and class may affect the experience of paranoia. Social inequality exerts its effect partly through those categories. However, there are other ways that inequality can affect paranoia. For example, there appear to be links between distress and measures of social trust (Giordano and Lindström, 2011; Ross et al., 2001) which can be affected by crime and other

neighbourhood problems (Ross et al., 2001). Trust, a key aspect of social capital, appears to have been declining in many industrialised nations over the last few decades (Putnam, 1995; Wilkinson & Pickett, 2009). There is some debate about this but if it is not an artefact, there is a need to understand why this is happening. Wilkinson and Pickett (2009) rightly argue for policymakers to do more to reduce the income inequality gap which may be one of the factors influencing the apparent decline in social trust. However, another potential contributory factor in relation to paranoia specifically, may be the way in which we conceive of and use public space. Minton (2009) for example, argues that recent developments in urban planning in industrialised societies like the UK – for example, homogenised shopping centres, gated communities and increasing amounts of open public space monitored by CCTV -- has led to increased fear between different social groups. We have noted that different social groups might feel and, indeed, might be more surveilled, reflecting social demarcations (Coleman & McCahill, 2011). How might trust be influenced by membership of social categories, given the differential impact of social inequality? Moreover, how might trust be increased? Certainly there is a need for policymakers to do more to help increase social trust and to counter the paranoia which seems to becoming an increasingly noticeable aspect of 21st century life in industrialised countries.

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