Author(s): David Harper
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The social context of paranoia

David J Harper

"Psychiatry", suggests Hornstein (2009a: 6), "is the most contested field in medicine" and, as Bracken and Thomas (2001: 724) note, "[i]t is hard to imagine the emergence of 'antipædiatrics' or 'critical anæsthetics' movements". But why is this so? One of the reasons is that there is often a fundamental disagreement about the meaning attributed to experience and, who has the right to confer that meaning. Experiences like paranoia are often decontextualised and stripped of meaning. For example, psychiatry variously classifies paranoia as a sub-type of schizophrenia, a separate delusional disorder or as a type of personality disorder. Yet arcane discussions of the differences between diagnostic sub-types distract from commonalities in the way paranoia is experienced.

In this chapter I investigate the concept of paranoia, paying attention to its contested nature. I take a deliberately broad view, seeing it as an apparently unwarranted fear and belief that others intend to harm one in some way, leading us to respond to others in a fearful, wary and even hostile manner. Deciding on the best way to address such distressing feelings very much

depends on what we think paranoia is and so, the chapter begins with an examination of some of the conceptual assumptions embedded in the notion.

Problematising paranoia

One of the core assumptions made when diagnosing paranoia is that the person is fearful or hostile because their beliefs about the intentions of others are false. In simple terms, their beliefs are delusional. According to the American Psychiatric Association a delusion is:

> A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g. it s not an article or religious faith). When a false belief involves a value judgement, it is regarded as a delusion only when the judgement is so extreme as to defy credibility. Delusional conviction occurs on a continuum and can sometimes be inferred from an individual's behaviour. It is often difficult to distinguish between a delusion and an overvalued idea (APA, 2000: 821).

For a delusion to be considered paranoid (or 'persecutory' in psychiatric terms) the central theme of the belief is that the person (or someone close to them) is being victimised or conspired against in some way and there is an

explicit intention to harm them.

Definitions like these have been challenged on conceptual and empirical grounds over the years (e.g. Boyle, 2002; David, 1999; Freeman & Garety, 2000; Harper, 1996, 2004; Moor & Tucker, 1979; Oltmanns, 1988; Spitzer, 1995). Indeed, one commentator has noted that: "despite the façade created by psychiatric textbooks, there is no acceptable (rather than accepted) definition of a delusion" (David, 1999: 17). There have been attempts to re-label delusions as 'abnormal beliefs' or 'unusual beliefs'. Oltmanns (1988) has argued that rather than trying to settle on a fixed definition of delusion, it might be better to elucidate seven 'defining characteristics' by which delusions might be recognised with none of the characteristics being seen either as essential or sufficient for a diagnosis. This approach clearly provides some flexibility but this can also be problematic in that diagnoses can prove to be too flexible. As the Rosenhan (1973) study showed it can be quite hard to prove that one does not fulfill psychiatric criteria once one has been given a diagnosis, and diagnosers appear to show a great deal of flexibility in which criteria they draw on and how they interpret them (Harper, 1994). For example, if a person does not fit the criteria for delusion, the *DSM* definition of paranoid personality disorder is very similar: "distrust and suspiciousness of others such that their motives are interpreted as malevolent…individuals with this disorder assume that other people will exploit, harm or deceive them, even if no evidence exists to support this expectation" (APA, 2000: 690).

Boyle (2002: 279) argues that diagnostic debates are so long-lived because researchers have an 'assumptive framework' which remains 'unexamined or even unarticulated'. In this chapter, I examine the assumptive framework of contemporary notions of paranoia and delusion and argue that the Oltmanns approach, like that of the *DSM-IV*, rests on four fundamental assumptions that obscure more helpful ways of looking at relatively enduring beliefs, fears and ways of relating to others.

Naïve realism

One of the most basic problems is the assumption that it is possible to prove that a person's beliefs are false – a naively realist worldview. Yet we know that most people end up with a diagnosis of paranoia without independent empirical investigation – probably the most that will have happened is a psychiatric interview with the person and possibly a family member. Maher has argued assessment of the plausibility of a person's beliefs is "typically made by a clinician on the basis of 'common sense', and not on the basis of a systematic evaluation of empirical data [and that it is not] customary to present counterevidence to the patient; it is not even common to present vigorous counterargument" (Maher, 1992: 261). These observations have empirical support: based on a study of out-patient psychiatric consultations McCabe, *et al* reported that: "[w]hen patients attempted to present their psychotic symptoms as a topic of conversation, the doctors hesitated and

avoided answering the patients' questions, indicating reluctance to engage with these concerns" (2002: 1150). It is ironic that service users are required to provide proof for their claims but the threshold appears to be lower for professionals. Indeed, researchers often report examples of delusions that either turned out to be true or which had a 'kernel of truth' in them (Barrett, 1988).

If the diagnosis of a delusion is based more on a judgement of plausibility than an empirical investigation, then it means that different diagnosers may arrive at different conclusions - posing problems for the reliability of diagnoses of delusions. Of the few studies of diagnostic reliability reported, despite significant methodological weaknesses, quite varied results are found with judgements of the bizarreness of delusions particularly poor (Bell, Halligan & Ellis, 2006; Harper, 1999). However, how many of us could say that we have objective evidence for any, let alone all, of our beliefs? Is it even possible or desirable to have 'evidence' for political, ethical, and spiritual or religious beliefs? So the idea that beliefs are straightforwardly empirically verifiable is problematic. Given this, it is perhaps not unsurprising that judging whether a belief is abnormal in some way is even more of a challenge.

How abnormal are abnormal beliefs?

It is commonly assumed that the kinds of beliefs which are diagnosed as delusional are rare and such beliefs are statistically abnormal. However,

when surveys of the general public are conducted, we find that potentially 'delusional' beliefs are not as unusual as might be thought. For example, one UK survey reported that 45% of people believed in telepathy, 45% believed in the ability to predict the future, 42% believed in hypnotism, 39% believed in life after death, 39% believed in faith healing and 31% of people believed in ghosts (Social Surveys/Gallup Poll Ltd, 1995). A more recent American Gallup survey reported slightly lower percentages though belief in ESP was at 41%, but 73% of Americans believed in at least one of 10 paranormal items (Moore, 2005).

It is even harder to evaluate beliefs when it comes to social judgments about others. A 1994 Gallup survey reported that 24% of people admitted lying at least once the previous day and 64% thought they had been lied to at least once the previous day (Social Surveys/Gallup Poll Ltd, 1994). In a further survey, 60% of people felt that one could not be too careful in dealing with people and only 37% felt most people could be trusted (Social Surveys/Gallup Poll Ltd, 1997). Given these levels of trust in others it seems that some level of paranoia is relatively commonplace.

One objection to this might be that belief in ghosts and so on is a different matter to belief in something 'properly' delusional. However, Emmanuelle Peters and colleagues at the Institute of Psychiatry have conducted some interesting studies using the *Peters Delusions Inventory* or PDI (Peters, Joseph

& Garety, 1999a), a short self-report questionnaire containing questions about beliefs drawn from schedules of psychiatric symptoms. It is deliberately phrased using everyday words rather than psychiatric terminology – examples include 'do you ever feel as if people seem to drop hints about you or say things with a double meaning?' and 'do you ever feel as if you are being persecuted in some way?' For each belief three ratings are made: the conviction with which it is held; the amount of distress associated with it; and the extent to which the person is preoccupied with it.

In one study Peters and her colleagues reported that although 'psychotic inpatients' had higher scores on the PDI than the general population (Peters, *et al*, 1999a) there was also considerable overlap between the two groups. In other words, some members of the general public scored *higher* on the delusions survey than those who were psychiatric inpatients. This finding has since been replicated using a much larger general population sample (Peters, *et al*, 2004). Where the two groups in this study appeared to differ was that the general public were less preoccupied with, distressed by and convinced by their beliefs.

In a separate investigation, Peters, *et al* (1999b) compared members of New Religious Movements (Druids and Hare Krishnas), non-religious people, Christians and 'deluded people' on their scores on the PDI measure. They found no differences between the members of New Religious Movements and

'deluded people' in terms of either the number of beliefs held or the strength with which they were held. The only differences between the groups were in how preoccupied the participants were with their beliefs and how distressed they were about them.

Thus, whereas traditional psychiatric approaches assume that it is the *fact* of holding a belief considered delusional that is the problem, this research indicates that the key issue is the *relationship* people have with their beliefs – in other words, whether your beliefs get in the way of the life you wish to lead.

A number of studies report similar results with the PDI in France, the Netherlands and New Zealand, with anywhere between 3%-20% of the population holding beliefs which would, conventionally, be regarded as delusional. In another study, nearly half of a sample of British college students reported an experience of paranoia including a clear statement that they felt there had been a planned intention to harm them -- the key criterion for a diagnosis of a paranoid or persecutory delusion (Ellett, Lopes & Chadwick, 2003). Freeman has noted that a: "conservative estimate is that 10–15% of the general population regularly experience paranoid thoughts" (Freeman, 2007: 430). In a community survey of a random sample of 7, 076 people in the Netherlands, van Os, *et al* (2000) reported that 8.7% of the sample had delusional beliefs but that 3.3% had 'true' delusions. In other

words, 8.7% of the population held beliefs that fulfilled most of the diagnostic criteria for delusions but did not require clinical intervention – they did not appear to be causing the person or those around them clinically significant levels of distress or causing problems in their daily life. This means that although 5.4% of the sample had beliefs which psychiatrists would diagnose as delusions, they were managing to go about their everyday lives apparently without problems. Similarly, a survey of the US general population suggested that 4.41% of the population met the criteria for a diagnosis of paranoid personality disorder (Grant, *et al*, 2004).

What are we to make of surveys like these? They show that 'paranoid' experiences are not nearly as unusual or abnormal as we are led to believe. Since referrals to mental health services in no way match these levels, this either indicates a serious level of under-diagnosis or that many people with such experiences do not require help from mental health services. How might some people manage to hold beliefs which might be seen as delusional and yet manage to avoid being referred to, or seeking help from, mental health services? Weeks and James (1997) have researched the similar topic of 'eccentricity' and identify a number of people who remain happy and engaged with the world despite holding unconventional views. Sun Ra and David Icke are examples of people whose beliefs others might find unusual but who do not appear to have experienced distress because of their beliefs or been in receipt of mental health services.

Sun Ra was a black American avant garde musician who, from the 1950s until his death in 1993, led a jazz group called the Arkestra. He claimed to be from the planet Saturn, tracing this realisation to a religious vision he had in the 1930s (Szwed, 1998). He has been the subject of a number of documentary films including Don Letts' *Brother from Another Planet – The Sun Ra Story*.

David Icke was a BBC TV sports presenter who became involved in the Green party in the late 1980s. A week after resigning from the Green Party he held a press conference to announce that he had become a "channel for the Christ spirit" and predicted that the world would end in 1997 after a series of natural disasters. He has gone on to write a number of books about his ideas, in particular that the world is being run by a race of shape-shifting alien lizards who have inter-bred with humans and can appear in human form (see www.davidicke.com). According to journalist Jon Ronson his career is "a global sensation" and "he lectures to packed houses all over the world" (Ronson, 2001: 151).

Is paranoia meaningless?

The influence of biological and reductionist traditions in psychiatry has meant that mental health professionals have traditionally been little interested in the content of people's experiences. Thus, historically, there has been more interest in *whether* someone heard a voice rather than in *what the voice said*. Similarly, the assumption has generally been that beliefs seen as delusional or

paranoid are meaningless -- an 'empty speech act' (Berrios, 1991) -- and that exploring them will mean that the clinician is 'colluding' with the belief.

However, there is mounting evidence that such beliefs are full of meaning. One study reported that those with a diagnosis of delusions scored as highly on a measure of purpose and meaning in life as those training to be Anglican priests (Roberts, 1991). This suggests that these beliefs may actually give people a meaning in life even though, in the case of those who feel paranoid, the meaning may not be at all pleasant (Harper, 2008). This is, perhaps, not that surprising: if you are unemployed, poor and living alone on a frightening housing estate with little money to spend in occupying yourself, it may be functional to imagine you are Jesus, or are being followed by MI5. Other research has reported finding a correspondence between the themes in a person's 'delusions' and their everyday life or their past (Rhodes & Jakes, 2000).

An important line of research has been the investigation of links between paranoid beliefs, social inequality and victimisation. For example, John Mirowsky and Catherine Ross (1983) conducted a survey of the general population in El Paso, Texas and across the border in Juarez, Mexico. They reported that those with the most paranoid beliefs tended to be working class Mexican women -- those who were in social positions characterised by powerlessness, the threat of victimisation and exploitation. Again, this should

not be all that surprising. When you are not fully in control of your life - when, for example, you could be sacked from your poorly paid job at any moment - in a very real sense others *are* in control of your life and it may feel as if they are persecuting you.

Racism also plays a part here, and a range of empirical work indicates that it may be one of the causes of the high rates of psychosis in the black population. For example, black and Asian people in the UK are 50 per cent more likely to be diagnosed with schizophrenia than white people (King, *et al*, 1994). Moreover, the prevalence of schizophrenia diagnoses is higher among black people living in majority white areas (Boydell, *et al*, 2001). A community survey in the Netherlands noted that those meeting diagnostic criteria for delusions were more likely to report having experienced discrimination previously (Janssen, *et al*, 2003). Similarly, Karlsen and Nazroo (2002) have noted that those belonging to minority ethnic groups were much more likely to have psychotic symptoms if they reported experiencing racist victimisation in the previous year. Lastly, experiences of victimisation and stressful life events were among the correlates of psychotic symptoms in a large UK community survey (Johns, *et al*, 2004).

John Cromby and I have argued that, rather than seeing paranoia as a kind of belief, it makes sense to view it as a kind of story that is embodied within us as a result of our life experiences (Cromby & Harper, 2009). It may help

someone to make sense of a confusing world -- where they feel influenced by forces beyond their immediate perceptions – to connect apparently unconnected happenings. It may be that, in its focus on whether supposedly delusional beliefs are *literally* true, reductionist psychiatry has missed the more important issue that many such beliefs may be *metaphorically* true, reflecting the influence on the person's life of a range of stressful experiences, including those resulting from social inequalities.[1]

So far, in this chapter, I have argued that the assumptive framework underpinning the psychiatric notion of paranoia presupposes: a naïve realist model of the world; that paranoid beliefs are inherently pathological and abnormal; and that they are meaningless. But who is given the power to make these judgements and what is the basis for the legitimacy of their claims?

Who gets to decide what is "normal"?

Of course, one of the key assumptions made when we say someone has a delusion is that this is a statement of *fact* rather than *opinion*. In his seminal social constructionist analysis of delusions over twenty years ago, Heise (1988) argued that in the diagnostic interview one person's version of reality (the mental health professional's) is seen as more true than the other person's

1 This perspective is, of course, beautifully illustrated in R.D. Laing's (1960) case study of "*The Ghost of the Weed Garden*".

version of reality (the service user's) as the professional is granted, by virtue of their social position, the power to define reality. Eugenie Georgaca has investigated this empirically, using discourse analysis to examine interviews conducted with psychiatric service users considered delusional (2000, 2004). She argues that, contrary to received opinion, service users are able to provide evidence for their beliefs and to engage in discussion with others about them. The problem which arose is that what some of her interviewees saw as persuasive evidence was not persuasive to her. Moreover, she noted that many of their claims were epistemologically ambiguous in that they would be hard to verify empirically and they were certainly impossible to test within the context of an interview (as occurs in most psychiatric diagnostic interviews). She argued that judging another's beliefs to be delusional was an interactional accomplishment, one in which the hearer of the belief (and their assumptions about the world) was important but ignored within the psychiatric literature.

The psychiatrist Suman Fernando has made a similar point:

> in the process of making a diagnosis, judgements are hypothesized as symptoms and illnesses -- as 'things' that exist in some way separately from the people who make the judgements and from the people ('patients') who are said to 'have' them (Fernando, 1997: 16).

In other words, when we say that someone "has a deluded belief", what we are *really* saying is "that idea is implausible to me", "I don't understand that

idea" or even "that idea is dangerous". The process by which we come to these judgements occurs between people in conversation and it is likely to be influenced by all of the things that make us different from each other. There is one area of belief which throws this assumption into particular relief.

In a sense, when mental health professionals make judgements about whether beliefs are normal, they are making proxy judgements on behalf of all of us. But what is the standard against which they are judging beliefs? If this standard remains implicit, and if mental health professionals are actually significantly different from the general population, then this causes further problems for diagnosis. In fact, this is the case with religious belief where a number of surveys suggest that it is mental health professionals who are the 'abnormal' ones, statistically speaking. For example, Smiley (2001) asked British clinical psychologists about their religious belief and found that, whereas 61% of psychologists reported having no religious belief, or were agnostic or atheistic, only 28% of the population as a whole did.

Implications: Changing assumptions and changing society

We have seen how the 'assumptive framework' constructing paranoia influences both how it is experienced and how it is diagnosed by professionals. Here, I outline some implications of this analysis for practice,

research and policy.

Practice

Therapists need to acknowledge that judgments about beliefs are social and cultural and so it may be more helpful to focus on the 'fit' between a person's beliefs and the lives they wish to lead rather than on the veracity of the belief. There could be a focus on the content and context of the belief, particularly its historical and biographical context, given that many of these beliefs appear to occur in late adolescence and/or following experiences of victimization. Therapeutic factors in alternative groups seem to involve helping the person to develop an explanation for their experiences which: makes sense to them; does not unduly distress them; puts them in contact with a community which shares those meanings since social isolation is generally anti-therapeutic; where there are often rituals, practices and other regular activities which ground the person in this community; and which allows them to lead the lives they wish to (Romme & Escher, 2000).

The development of paranoia support groups can help to combat the isolation that can be a consequence of some frightening beliefs and is an example of how people with distressing beliefs can help each other to cope (Bullimore, 2010a; James, 2003; Knight, 2009). For those not able or willing to meet with others, the internet can be a useful resource though this can become unhelpful

if it begins to dominate the person's life.

Community psychology is another useful approach. May (2007) has discussed the development of community-based approaches for people having experiences others consider psychotic. Sue Holland's (1991) White City project developed a model of social action psychotherapy. She focused on women on a West London estate, offering a staged approach beginning with a number of sessions of individual therapy, leading into group work and then into collective social action. Of course, therapeutic work can only go so far and there is a need to influence researchers and policy makers too.

Research

An obstacle to research progress is the psychiatric diagnostic enterprise itself. I would argue that, certainly in the area of psychosis, diagnostic categories are actively unhelpful in that their use requires us to make many *a priori* assumptions about the nature of the phenomena they purportedly categorise. As Rogers and Pilgrim (2003) note, researchers attempting to trace the relationship between social disadvantage and mental health are often forced to use such categories as epidemiological data are structured by them. Fortunately, the availability of dimensional experience or symptom-based measures like the PDI provide an alternative.

We need, instead, to return to a focus on experience. What is it like to feel

paranoid? Here qualitative research can be helpful in capturing the nuances of subjective experience. In particular it can be helpful to investigate experience outside of the clinic and to explore trust, mistrust and suspicion in a range of contexts, including the everyday (King, *et al*, 2008; Willig, 1997). In trying to understand experience we need to use language but this, too, contains many presuppositions. Indeed, Wallcraft and Michaelson (2001) have argued for the development of a 'survivor discourse' in order to reclaim the language used to describe their experience back from professionals. We need to rethink the language we use to describe paranoia and similar experiences. But what alternatives to the terms 'paranoia' or 'delusion' are there? The move from 'auditory hallucination' to 'voice hearing' in the 1990s was useful because it was behaviourally descriptive, carried little conceptual baggage and was open to different interpretations. The term 'paranoia' is challenged by some because it is thought to imply that such beliefs are inherently pathological - but this need not be the case and some survivors use it to describe their experiences since it is widely understood. There is much less agreement about the term 'delusion' or even about the term 'belief'. However, there is no obvious replacement. I do not think the term 'unusual belief' is necessarily better than delusion – unusual to who? Other alternatives abound (e.g. 'unshared beliefs', 'having an alternative sense of reality' or 'heightened sensitivity to others' or Tamasin Knight's 'beliefs that might not be easily confirmable' see Hornstein, 2009b: 136).

Whatever words we use to describe paranoia, I would argue that we need to move research away from its focus on truth as a key factor given that it is rarely the key issue. David Heise made a similar point over twenty years ago when he argued that the "factuality of belief" be discarded as a diagnostic criterion and the "focus on sociality sharpened" (Heise, 1998: 270). If researchers were less enchanted by whether beliefs were true it might be easier to focus on the 'fit' between a person's beliefs and the life they wish to lead. What influences are there on that 'fit'? How do some people manage to live lives as 'mystics', 'eccentrics' or even 'extremists' (the subject of investigations by Peters, 2001; Weeks & James, 1997; and Ronson, 2001 respectively) rather than as psychiatric patients? If we begin to see 'delusions' as positions that people take up and/or are positioned in, in discourse what alternative modes of understanding might this open up? Fruitful avenues appear to be narrative (de Rivera & Sarbin, 1998) and dialogical models (Hallam & O'Connor, 2002). Indeed, how is it that some belief claims seem more plausible than others, or to some people than others?

Policy

> [t]he more equitable the distribution of wealth in a country, the more trusting its people will be (Uslaner, 2002: 230 cited in Freeman & Freeman, 2008).

When mental health practitioners seek to influence policymakers there is a danger that they suggest solutions at the level of the individual – usually

some form of medication or psychotherapy. Apart from being self-serving, this approach is too costly to be available for all those who might 'need' it and, moreover, it is ameliorative, rather than preventative. On the rare occasions that mental health services are involved in preventative efforts, the concern is often to target intervention on 'high risk groups'. However, Huppert suggests that this may be short-sighted as: "the majority who develop disorder come not from the high risk group, but from the general population, simply because the members of the general population are so numerous" (Huppert, 2009: 109). Instead, Huppert makes a case for focusing interventions at the population level since: "a small shift in the population mean is associated with a substantial reduction in the prevalence of disorder" (Huppert, 2009: 109-110).

When we look at paranoia at the population level, it is hard to say whether we are 'more' paranoid than we were in the past (Freeman & Freeman, 2008) but, surveys show that levels of trust between people in Britain have been decreasing over the last fifty years. Moreover, neighbourhoods reporting low levels of overt mutual trust are the most disadvantaged and where there is most social disorder like crime, vandalism and so on (Ross, Mirowsky & Pribesh, 2001). What is interesting is that, at the population level, levels of trust appear to be correlated not with overall levels of income, but with the difference between the poorest and the richest in society – in other words, they are related to levels of income inequality. In *The Spirit Level*, Richard

Wilkinson and Kate Pickett present persuasive evidence of this. In general, those countries with the lowest levels of income inequality (e.g. Sweden, Norway, Denmark and Finland) are also those countries reporting the highest levels of trust. Wilkinson and Pickett (2009) show that a similar pattern is also seen in the USA between States which vary in terms of income inequality. Moreover, it appears that as inequality increases, trust decreases. Addressing such inequality requires action beyond the clinic.

When we use the notion of paranoia to diagnose others we may obscure the real causes of their distress, locating it instead in faulty brain mechanisms, rather than out there in a frequently hostile world. Likewise, when we experience paranoia we have the sense that we are the ones who know what is really going on in the world but paranoid ideas may simply mystify the causes of the real inequalities and victimisations we have experienced, transforming them into a dramatic personalised narrative (Harper, 2008). Perhaps we can 'decode' the metaphorical meaning of paranoia, enabling people to trace the influence of power on their life (May, 2007)? The liberation psychologist, Ignacio Martin-Baro described a process which he termed *conscientización* whereby people could educate and liberate themselves from oppressive social conditions (Burton, 2004). If we are to fully locate paranoia in its social context, we need not only to raise awareness of that context but also to seek to change it.

References

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders.* Fourth Edition, Text Revision. Arlington, VA: Author.

Barrett, R.J. (1988). Clinical writing and the documentary construction of schizophrenia. *Culture, Medicine & Psychiatry,* 12, 265-99.

Bell, V., Halligan, P.W. & Ellis, H.D. (2006). Diagnosing delusions: A review of inter-rater reliability. *Schizophrenia Research*, 86, 76-9.

Berrios, G.E. (1991). Delusions as 'wrong beliefs': A conceptual history. *British Journal of Psychiatry,* 159 (suppl. 14), 6-13.

Boydell, J., van Os, J., McKenzie, K., Allardyce, J., Goel, R., McGreadie, R.G. & Murray, R.M. (2001). Incidence of schizophrenia in ethnic minorities in London: Ecological study into interactions with environment. *British Medical Journal*, 323, 1336–38.

Boyle, M. (2002). *Schizophrenia: A scientific delusion?* Second edition. London: Routledge.

Bracken, P. & Thomas, P. (2001). Postpsychiatry: A new direction for mental health. *British Medical Journal*, 322, 724-727.

Bullimore, P. (2010a). The paranoia group. *Asylum: The Magazine for Democratic Psychiatry*, 17(1), 26.

Burton, M. (2004). Liberating psychology in Latin America. *The Psychologist,* 17, 584–7.

Cromby, J. & Harper, D. (2009). Paranoia: A social account. *Theory & Psychology*, 19, 335–61.

David, A.S. (1999). On the impossibility of defining delusion. *Philosophy, Psychiatry & Psychology*, 6, 17-20.

de Rivera, J. & Sarbin, T. (Eds) (1998). *Believed-in Imaginings: The narrative construction of reality*. Washington DC: American Psychological Association.

Ellett, L., Lopes, B. & Chadwick, P. (2003). Paranoia in a nonclinical population of college students. *Journal of Nervous and Mental Disease*, 191, 425-30.

Fernando, S. (1997). Peeling labels. *Open Mind*, 87, 16-17.

Foress Bennett, J. (1997). Credibility, plausibility and autobiographical oral narrative: Some suggestions from the analysis of a rape survivor's testimony. In A.Levett, A. Kottler, E. Burman & I. Parker (Eds) *Culture, power & difference: Discourse analysis in South Africa*. London: Zed Books.

Freeman, D. (2007). Suspicious minds: The psychology of persecutory delusions. *Clinical Psychology Review*, 27, 425–57.

Freeman, D. & Freeman, J. (2008). *Paranoia: The twenty-first century fear*. Oxford: Oxford University Press.

Freeman, D., & Garety, P. A. (2000). Comments on the content of persecutory delusions: Does the definition need clarification? *British Journal of Clinical Psychology*, 39, 407−14.

Georgaca, E. (2000). Reality and discourse: A critical analysis of the category of 'delusions'. *British Journal of Medical Psychology*, 73, 227-42.

Georgaca, E. (2004). Factualization and plausibility in 'delusional' discourse. *Philosophy, Psychiatry & Psychology*, 11, 13-23.

Grant, B.F., Hasin, D.S., Stinson, F.S., Dawson, D.A., Chou, S.P., Ruan, W.J. & Pickering, R.P. (2004). Prevalence, correlates, and disability of personality disorders in the United States: Results from the national epidemiologic survey on aalcohol and related conditions. *Journal of Clinical Psychiatry*, 65, 948-58.

Hallam, R.S. & O'Connor, K.P. (2002). A dialogical approach to obsessions. *Psychology and Psychotherapy: Theory Research and Practice*, 75, 333-48.

Harper, D. J. (2008). The politics of paranoia: Paranoid positioning and conspiratorial narratives in the surveillance society. *Surveillance & Society*, 5, 1, 1-32.

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

Harper, D.J. (1999). Deconstructing paranoia: An analysis of the discourses associated with the concept of paranoid delusion. Unpublished PhD thesis: Manchester Metropolitan University

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

Psychology, 6, 423-48.

Harper, D.J. (1994). The professional construction of 'paranoia' and the discursive use of diagnostic criteria. *British Journal of Medical Psychology*, 67, 131-43.

Heise, D. R. (1988). Delusions and the construction of reality. In T. F. Oltmanns & B.A. Maher (Eds). *Delusional beliefs*. New York. Wiley.

Holland, S. (1991). From private symptom to public action. *Feminism & Psychology*, **1**, 58-62.

Hornstein, G.A. (2009a). Who owns the mind? *Open Mind*, 157, 6-8.

Hornstein, G.A. (2009b). *Agnes's Jacket: A psychologist's search for the meanings of madness*. New York: Rodale Press.

Huppert, F.A. (2009). A new approach to reducing disorder and improving well-being. *Perspectives on Psychological Science*, 4, 108-11.

Ingelby, D. (1982). The social construction of mental illness. In P. Wright & A. Treacher (Eds). *The Problem of Medical Knowledge: Examining the social construction of medicine*. Edinburgh: Edinburgh University Press.

James, A. (2003). Voices of reason. *The Guardian*, 10 December. http://society.guardian.co.uk/societyguardian/story/0,7843,1103141,00.html, accessed 8 February 2010.

Janssen, I., Hanssen, M.A., Bak, M., Bijl, R.V., de Graaf, R., Vollebergh, W. & van Os, J. (2003). Discrimination and delusional ideation. *British Journal of Psychiatry*, 182: 71-76.

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

Karlsen, S. & Nazroo, J.Y. (2002). Relation between racial discrimination, social class and health among ethnic minority groups. *American Journal of Public Health*, 92, 624-31.

King, M., Coker, E., Leavey, A., Hoare, A. & Johnson-Sabine, D. (1994). Incidence of psychotic illness in London: Comparison of ethnic groups. *British Medical Journal*, 309, 1115–19.

King, N., Finlay, L., Ashworth, P., Smith, J.A., Langdridge, D. & Butt, T. (2008). "Can't really trust that, so what can I trust?": A polyvocal, qualitative analysis of the psychology of mistrust. *Qualitative Research in Psychology*, 5, 80–102.

Knight, T. (2009). Beyond belief: Alternative ways of working with delusions, obsessions and unusual experiences. Berlin: Peter Lehmann Publishing. Available for free download from: http://www.peter-lehmann-publishing.com/beyond-belief.htm, accessed 15 January, 2010.

Laing, R.D. (1960). *The Divided Self*. London: Tavistock.

Maher, B.A. (1992). Delusions: Contemporary etiological hypotheses. *Psychiatric Annals*, 22, 260-8.

May, R. (2007). Working outside the diagnostic frame. *The Psychologist*, 20, 300-1.

McCabe, R., Heath, C., Burns, T. & Priebe, S. (2002). Engagement of patients with psychosis in the consultation: Conversation analytic study. *British Medical Journal*, 325, 1148-51.

Mirowsky, J. & Ross, C.E. (1983). Paranoia and the structure of powerlessness. *American Sociological Review*, 48, 228-39.

Moor, J. H & Tucker, G.J. (1979). Delusions: Analysis and criteria. *Comprehensive Psychiatry*, 20, 388-93.

Moore, D.W. (2005). Three in four Americans believe in paranormal: Little change from similar results in 2001. Available from: http://www.gallup.com/poll/16915/Three-Four-Americans-Believe-Paranormal.aspx. Accessed 13 January 2010.

Morrison, A.P. (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy*, 29, 257-76.

Oltmanns, T. F. (1988). Approaches to the definition and study of delusions. In T. F. Oltmanns & B. A. Maher (Eds). *Delusional Beliefs*. New York: Wiley.

Peters, E. (2001). Are delusions on a continuum? The case of religious and delusional beliefs. In I. Clarke (ed), *Psychosis and Spirituality: Exploring the new frontier*. London: Whurr.

Peters, E., Joseph, S., Day, S. & Garety, P. (2004). Measuring delusional

ideation: The 21-Item Peters et al Delusions Inventory (PDI). *Schizophrenia Bulletin*, 30, 1005-22.

Peters, E.R., Joseph, S.A. & Garety, P. (1999a). Measurement of delusional ideation in the normal population: Introducing the PDI (Peters et al Delusions Inventory). *Schizophrenia Bulletin*, 25, 553-76.

Peters, E., Day, S., McKenna, J. & Orbach, G. (1999b). Delusional ideation in religious and psychotic populations. *British Journal of Clinical Psychology*, 38, 83-96.

Rhodes, J.E. & Jakes, S. (2000). Correspondence between delusions and personal goals: A qualitative analysis. *British Journal of Medical Psychology*, 73, 211-25.

Roberts, G. (1991). Delusional belief systems and meaning in life: A preferred reality? *British Journal of Psychiatry*, 159 (suppl. 14), 19-28.

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

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

Ronson, J. (2001). *Them: Adventures with extremists*. London: Picador.

Rosenhan, D. L. (1973). On being sane in insane places. *Science*, 179, 250-8.

Ross, C.E., Mirowsky, J., & Pribesh, S. (2001). Powerlessness and the amplification of threat: Neighbourhood disadvantage, disorder and mistrust. *American Sociological Review, 66,* 568–91.

Smiley, T. (2001). Clinical psychology and Religion: A survey of the attitudes

and practices of clinical psychologists in South East England. Unpublished Psych.D thesis: University of Surrey.

Social Surveys/Gallup Poll Ltd (1994). Lying. *Gallup Political and Economic Index*, 404, 24.

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

Social Surveys/Gallup Poll Ltd. (1997). Trust in people. *Gallup Political Index*, 437, 26.

Spitzer, M. (1995). Conceptual developments in the neurosciences relevant to psychiatry. *Current Opinion in Psychiatry*, 8, 317-29.

Szwed, J.F. (1998). *Space is the Place: The lives and times of Sun Ra*. Cambridge, MA: Da Capo Press.

Uslaner, E. (2002). *The Moral Foundations of Trust*. Cambridge: Cambridge University Press.

van Os, J., Hanssen, M., Bijl, R.V. & Ravelli, A. (2000). Strauss (1969) revisited: A psychosis continuum in the general population? *Schizophrenia Research*, 45, 11-20.

Wallcraft, J. & Michaelson, J. (2001). Developing a survivor discourse to replace the 'psychopathology' of breakdown and crisis. In C. Newnes, G. Holmes & C. Dunn (Eds). *This is Madness Too: Critical perspectives on mental health services*. Ross-on-Wye: PCCS Books.

Weeks, D. & James, J. (1997). *Eccentrics*. London: Phoenix.

Wilkinson, R. & Pickett, K. (2009). *The Spirit Level: Why more equal societies*

almost always do better. London: Allen Lane.

Willig, C. (1997). The limitations of trust in intimate relationships: Constructions of trust and sexual risk taking. *British Journal of Social Psychology*, 36, 211-21.