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Deconstructing 'paranoia':

Towards a discursive understanding of apparently unwarranted suspicion

David J. Harper

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Biography

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Abstract

'Paranoia' is a construct which is currently associated with types of 'schizophrenia', 'personality disorder' and 'delusional disorder' in DSM-IVTM (American Psychiatric Association, 1994). In this paper, the concept of paranoia is deconstructed by examining six dominant and six opposed and subjugated presuppositions within both the psychiatric and abnormal psychology literature. In an argument which aims to provide a positive deconstruction, a discursive approach is suggested as a perspective which transforms these oppositions and enables more creative theorizing.

Deconstructing 'paranoia':

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Not probing or challenging the categories, divisions, and objects that we encounter ... but rather treating them as 'givens' of the world, is to participate in a political act that helps affirm current formulations by never examining how they became current and whose interests they serve.

Sampson (1993, p.1223)

Beyond the pathologizing of 'paranoia' ¹

Recent critical analysis has begun both to examine the 'psy' disciplines at a broad level (e.g. Rose, 1989) and to focus on the institutional practices of branches of those disciplines: see Burman (1994) and Morss (1992) on developmental psychology, Parker & Shotter (1990) on social psychology and McNamee & Gergen (1992) on therapy. In contrast, this paper will focus on a particular concept used by those professions allied to the 'psy complex' - that of paranoia.

Paranoia as understood both by DSM-IV^{TM 2} (American Psychiatric Association, 1994) and ICD-10 (World Health Organization, 1992) may refer to a type of personality disorder, a type of schizophrenia or to a delusional disorder (e.g. Delusional Disorder: Persecutory type in DSM-IV). It is not the intention here to survey current theories of paranoia and delusion since a number of comprehensive reviews exist (e.g. Bentall,

1994; Butler & Braff, 1991; Hingley, 1992; Maher, 1992; Oltmanns & Maher, 1988; Winters & Neale, 1983).

Harper (1992) claimed to provide a 'loose deconstruction' of the concept of paranoid delusion from a social constructionist perspective (c.f. Gergen, 1985). Parker & Shotter (1990) have described three distinctive uses of the term deconstruction: the Derridian sense of revealing hidden contradictions within systematic texts; the Foucaultian sense of tracing the genealogy of institutional practices; and, finally the giving of a voice to the 'other' that is silenced and subjugated within a discourse. Harper's account dwelt on this first sense in that he illustrated the contradictory and problematic assumptions contained within DSM-III-R (American Psychiatric Association, 1987) of which paranoid delusions are a sub-set. This paper aims to further develop a deconstruction drawing on the notion of implicit oppositions using the second and third senses and, in particular, using ideas from discursive, rhetorical and textual psychology to aid a fuller understanding of the category termed paranoia.

Of course a full deconstruction of paranoia would be set against the background of a deconstruction and genealogy of the psychiatry/psychology/madness complex -- for further work on this see Foucault (1967), Gleeson (1991), Jodelet (1991), Parker, Georgaca, Harper, McLaughlin & Stowell Smith (forthcoming) and Rose (1985, 1989). Suffice it to say that asserting that the history of madness is one of psychiatric imperialism is to make a simplistic analysis. Such a statement would ignore the historical 'necessity' of the emergence of psychiatry (Foucault, 1980) and the move of the history of madness from one of 'negative operations' (e.g. the exclusion and

confinement of those considered mad) to a position in the nineteenth century where 'the technology of madness changed from negative to positive, from being binary to being complex and multiform. There came into being a vast technology of the psyche' (Foucault, 1980, p.185).

Deconstruction and mental health

The aim here is not simply to offer a critique since there are a number of problems with standard critiques. First, many commentators assume that an entity 'paranoia' exists whilst quibbling about 'its' nature. I hope to avoid this in the current text whilst recognising that it is difficult to talk about a concept without essentializing it (Sampson, 1993). A second problem with critiques is that they often use scientific concepts and rhetoric to question the scientific basis of psychiatric concepts and thus to unravel contradictions (e.g. Bentall, 1990; Boyle, 1990, 1994). More often than not such critics, whilst questioning some concepts like 'schizophrenia' find concepts of 'symptoms' like 'delusions' unproblematic (e.g. Bentall, 1990; Bentall, Jackson & Pilgrim, 1988). Third, many critiques, especially those labelled as 'anti-psychiatric' are often accused of denying that psychological distress exists.

This paper is deconstructive in the sense that it does not assume an entity called paranoia exists, rather it seeks to understand how that concept has come about. Spivak, who has described herself as a 'practical deconstructivist feminist Marxist' sees a difference between deconstruction and critique in that the latter is more interested in exposing error whereas the former looks to how truth is constructed (Spivak, 1990). Second, it does not seek to privilege 'science'. Instead, science will be seen as yet

another site at which stories of paranoia are produced. Finally, although belief in paranoia is suspended this does not mean I do not believe in the reality of emotional suffering. This would be stupid, particularly since in my work as a practising clinical psychologist I encounter such suffering every day. But what does it mean to believe in the reality of distress? Even Derrida has asserted that 'never have violence, inequality, exclusion, famine, and thus economic oppression affected as many human beings in the history of the Earth and of humanity' (Derrida, 1994, p.53).

There are clearly tensions, dilemmas and contradictions here and I feel that the cause of helping people in distress is not aided by straightforwardly pigeon-holing workers into whether they believe in suffering or not. The point is that distress is always mediated through concepts which are historically and culturally contingent. This is something acknowledged widely by those examining the history of madness (e.g. Bynum, Porter & Shepherd, 1985). In making such an assertion, this deconstruction aims to explore the processes and tensions involved in this mediation.

A deconstruction, or decomposition, as a strategy is not politically or practically impotent, it does not reduce everything to mere language games, nor does it deny reality as Sampson (1993) and Stenner & Eccleston (1994) have so convincingly demonstrated. Rather, it is often rooted in political struggles (Sampson, 1993; Stenner & Eccleston, 1994) or the concerns of practising clinicians (McNamee & Gergen, 1992; White, 1991; White & Epston, 1990). It concentrates on discourse in order to appreciate the work that is done in constructing paranoia. It emphasises textuality which affirms 'both the material substance of language and the textual substance of material' (Stenner

& Eccleston, 1994, p.85) and it foregrounds considerations of power.

Six oppositional presuppositions in traditional theorizing

The six oppositions focused on here are fixed together in a network of discourses to form a discursive complex. Discourses can be seen as 'sets of statements that construct objects and an array of subject positions, and discursive complexes contain specifications for types of object and shapes of subjectivity' (Parker, 1994, p.245). Of course, they also map onto other oppositions such as truth/lies, reality/illusion, objective/subjective and so on³. I assume that these have a relevance to other categories but limitations of space proscribe further discussion (for an elaboration see Parker, et al., forthcoming). This analysis will be attentive to that which is excluded or subjugated in the majority of texts. The aim of this deconstruction is not simply to privilege the subjugated term, however - deconstruction is not simple emancipatory and benevolent humanism. Rather it is to demonstrate how the dominant term is dependent on it, to dissolve the boundary and thus transform the opposition between the two terms in such a way that the dominant term cannot re-assert itself. Moreover, the task is also to see what is being kept at bay in maintaining such a strict boundary.

I. The individualization of suspicion

The DSM-IV definition of delusion, unchanged from DSM-III-R is a 'false personal belief' (p. 765). Most texts assume that paranoia is some kind of disorder located within the individual, perhaps indicating a biological cause. In this respect the category mirrors the operation of a whole range of concepts and practices of the psy complex which define, calibrate and govern the unitary rational subject - the depiction of which is grounded in

specific historical conditions (Foucault, 1979; Henriques, Hollway, Urwin, Venn & Walkerdine, 1984; Rose, 1989). Two conditions which are of most relevance here are the political context in which the category emerged and the disciplinary development of psychiatry.

Miller (1986), following the work of Castel (1976), has noted how new means of dealing with madness had to be found when the old basis of political legitimacy had begun to be removed in Western Europe, a means that 'was in accordance with the principles of a bourgeois "contractual" society' (Miller, 1986, p.36). Rose (1990) has suggested that it was at a similar time throughout Europe that the notion of governmentality and the requirement of some form of calibration and policing of the population became operable programmes. Psychiatry was one discipline which was able to step into the breach at this point and suspicion gradually became part, along with other aspects of social life, of that 'vast technology of the psyche' (Foucault, 1980, p.185) which was developing with the emergence of psychiatry as a viable discipline ⁴. It is important to note that the emergence of suspicion as a psychiatric concept through the demarcation of 'paranoia' thus occurred not just through the professional aspirations of medicine but also the political and historical necessities of the time.

Within this context, such a viewing of suspicion as an example of individual pathology had a number of important effects. First, it made a new sector 'of reality thinkable and practicable' (Rose, 1990, pp.105-6) in that forms of subjectivity became translated into languages of government and thus objects for rational management. Paranoia, along with a range of other concepts became an object which would be regulated through the

'systematic government of the psychological domain' (Rose, 1990, p.106) in order to 'govern subjectivity according to norms claiming the status of science' (Rose, 1990, p.110). In particular the assertion of paranoia as individual pathology conveyed the importance of trust, rationality, reasonableness, optimism as virtues of the new concept of self.

The concept of the individual enables such positioning although the literature allows for the diagnosis of two or more as suffering from folie à deux or folie à plusieurs (Enoch & Trethowan, 1991). However, although paranoia is regarded as an individualized concept, it is foregrounded against the social, and is therefore dependent on the social for its definition. According to DSM-IV, a delusion is held to be a belief not 'ordinarily accepted by other members of the person's culture or sub-culture' (p.765). Here there is a need for the social: there can only be said to be something wrong with the individual when they are compared with society. Thus although there are implicit individualist assumptions in DSM there are clearly also assumptions about the social (i.e. that it is rational, homogeneous and so on). A statistical argument might suggest that the implied construction of the social is contradictory since surveys report the wide currency of 'abnormal beliefs' in the general population of Western countries (e.g. the UK: Social Surveys/Gallup Poll Ltd., 1993). Of course, this simply illustrates that a 'belief' can be made to signify differently (widespread or abnormal) depending on the context.

These contradictions and ambivalences are often glossed over in critical accounts but are revealed in the dialectics of mental health practice. For example, one choice when

faced with the individual/social opposition is to privilege the social over the individual. Such concerns led to the development of the family therapy movement. However, increasingly there have been signs that family therapists are recalling the concept of the individual, arguing that the system (or family, or society) is composed of individuals and hence that change comes through the individual not the system (see e.g. Jenkins & Asen, 1992). Thus to attempt to fix meaning at the social end of the pole breaks down since 'society' becomes too abstract to operate and thus is then seen as constituted by 'individuals', but privileging the individual itself continually breaks down since the individual only exists against the background of society. One of the problems with arguing a solely 'social' and interactional account of madness (e.g. Lemert, 1962; Scheff, 1963), is that explanations of societal reactions either appear too abstract to theorize subjectivity (reducing social explanation to identification of a range of 'social factors' which impinge on an individual) or there is a resort to explaining the actions of collections of individuals. Simply privileging one side of the opposition, without challenging the other oppositions does not solve the problem, but simply transforms it.

II. The assumption of rationalism

DSM-IV speaks of notions of falsity, belief, inference, proof and evidence. The use of such terms points to an implicit positivism, empiricism and rationalism and a privileging, once again, of the unitary and rational subject. The paranoid is the person who fails to make logically defensible inferences on the basis of empirical data. Of course, the pursuit of rationality has been of major importance in Western philosophy since the time of Descartes. This was the time which Foucault (1967) saw as a defining moment: the birth at the same time of reason and unreason (or insanity). He pointed to the

importance of the existence of unreason in defining reason, memorably describing psychiatry as being a monologue of reason about madness. Boyne (1990) argues that in the first edition of Histoire de la folie Foucault was optimistic about the possibility of comprehending a 'pure' madness. Derrida, on the other hand, notes Boyne, claimed that every attempt by Reason (or any systematic text, for example, those produced by Foucault) to comprehend madness merely reproduced a version colonized and thus transformed by Reason.

The twin philosophies of rationalism and empiricism helped physicians concerned with those considered mad to establish a credible basis by claiming for their study and treatments the authority of science (Pilgrim, 1990). However, throughout the history of psychiatry the ambivalence between reason and unreason has continued producing two effects: any attempt to produce a totally rational account of insanity breaks down through contradictions of one kind or another; any attempt to talk about unreason renders it reasonable and no longer unreasonable. Thus forms of cognitive therapy which stress the importance of rationality are filled with many assumptions that are non-rational and unprovable, for example, that rationality is the best way to achieve mental health. Moreover psychodynamic accounts attempting to take the irrational seriously may end up with accounts punctuated by rationalism and reductionism like, arguably, those of Freud. The mainstream literature today sees a number of attempts to critique psychiatric nosology not only on moral and political but also on rationalist and empiricist grounds (Bentall, Jackson & Pilgrim, 1988; Boyle, 1990, 1994). Moreover, clinicians acknowledge the importance of non-rational and non-empirical influences on supposedly rational psychiatric decision-making. Indeed, Maher (1992) has noted that

beliefs are defined as delusional and false because they are deemed implausible with the assessment of plausibility 'typically made by a clinician on the basis of "common sense," and not on the basis of a systematic evaluation of empirical data' (Maher, 1992, p.261). Of course, one opposing argument could be that psychiatry make itself more rational and scientific (e.g. by adopting clearer diagnostic criteria and so on). This would ignore the assertion that at the heart of such a programme are certain 'hard core' assumptions which are not amenable to testing (Boyle, 1994).

As well as providing an authoritative basis for the mental health professions, the language of rationality and science is highly valued in the West. Once again, in defining the other as irrational, the definer marks themselves out as rational and empirical. But can it necessarily be rational to trust others or not? Ethnomethodologists argue that rationality is simply a particular form of life popular, for example, within spheres of science. Commentators like Schuetz (1943) and Garfinkel (1984) argue that there is no one reality, simply different perspectives. To adopt a rationalist scientific form of accounting then, in explaining everyday life would be a category mistake. The implicit empiricism of definitions of delusion is dependent on a naïve realism, on the possibility of unproblematically apprehending 'reality' in a direct manner, making 'correct inferences'. Harper (1992) has noted 'whatever the reality of reality it is clear we may construct different versions of it and that those which dominate are often the ones asserted by those in powerful positions' (1992, p.360).

The mental health literature contains numerous examples of the 'truth games' which surround paranoia. Thus there are cases where those diagnosed as paranoid are

reported to have fears which appear to be warranted and are, therefore, 'rational' (Menuck, 1992; Mayerhoff, Pelta, Valentino & Chakos, 1991). As Henry Kissinger has noted 'even a paranoid can have enemies' (quoted in Cohen & Cohen, 1980, p.188) ⁵. Maher (1988) has termed such cases examples of the 'Martha Mitchell Effect' after the late wife of President Nixon's Attorney General John Mitchell. Martha Mitchell alleged illegal activity was taking place in the White House. This 'was regarded as evidence that Mrs Mitchell was suffering from some kind of psychopathology until the revelations of the Watergate affair cast a new light on it all' (Maher, 1988, p.17). Such truth games, although appearing to undermine the validity of paranoia as a concept inadvertently strengthen it in using 'a foundationalist metaphor of a concrete reality lying behind or beneath a veil of deceptive appearances' (Stenner & Eccleston, 1994, p.89). Rather than beliefs thought to be delusional turning out to be true, I would argue that certain versions of events win the day through their political power rather than their inherent truth. Thus Martha Mitchell was 'proved right' because of the public political struggles over Watergate, not just the mere existence of, for example, Nixon's tapes.

III. The pathologization of suspicion

DSM-IV assumes that a paranoid belief is abnormal in some manner, for example is not acceptable to the individual's 'culture or sub-culture' (p.765). This assumption of abnormality is important since it is a foundation of 'psychopathology' or 'abnormal psychology'. In the same way as the establishment of reason creates unreason (and vice versa) so the operations of the psy complex function as dividing and excluding practices through the elaboration of an 'abnormal psychology'⁶. They seek to differentiate individuals, calibrating their properties and comparing them to an idealized

norm.

The assertion of pathology has important effects. Once again, for those who define others as pathological it secures a position of normality and it indicates that there is something 'wrong' with the pathological other. Moreover, it provides grounds for removing the legitimacy of the other's views. Paranoia operates as a regulation of suspicion, a de-legitimation of mistrust. Where an optimistic trust in the benevolence or indifference of others is most valued and seen as normal, paranoia is experienced as a powerful interruption in the world of our desires. Of course, it is no accident that the statistical concept of norm has moral and regulatory connotations. The establishment of concepts and practices which point to pathology within individuals parallels the development of a panoptical culture (Foucault, 1979). The importance of this is that not only are people positioned by others as pathological but they may also identify themselves as subject to a pathology as a result of various programmes of governmentality (Rose, 1989; Smail, 1984, 1987; White & Epston, 1990). Michael White has commented on how 'anorexia nervosa' can be seen as a system of self-government through:

the rigorous and meticulous self-surveillance, the various self-punishments of the body for its transgressions, the perpetual self-evaluations and comparisons, the various self-denials, the personal exile, the precise documentation, and so on.

Allen (1994, p.29)

In the same way, paranoia can be seen as another classic example of the power of panoptical culture to construct and thus 'bring forth' pathology (Méndez, Coddou &

Maturana, 1988). The person positioned as paranoid watches the self as well as others. Sass (1987) has departed from Freud's (1911) analysis and argued that the celebrated case of Daniel Schreber's paranoia is symbolic of a crisis of the modern soul. He has suggested that Schreber experienced a reified internalized surveillance as a result of persecutory and abusive parenting by his father, a writer on the topic of child-rearing. He was, Sass declares, a 'quintessentially panoptical being ... watching himself watching himself watching himself watch' (1987, p.144). Thus the power of pathology comes from its construction of a particular form of subjectivity and identity for the person considered paranoid. In the construction of that identity for the paranoid other lies the simultaneous construction of the normal non-pathological subject. Thus, once again we find the dominant pole of the opposition dependent on the other pole for its identity.

It is important to recognise however, that a paranoid identity does not always attract pathologization by others. A text like paranoia can be made to signify differently depending on when and where it is embodied, who it is that gives it voice and where power lies. There is a whole tradition of 'suspicious interpretation' (Fisher, 1992; Ricoeur, 1970) where meaning is derived from an inherent distrust of what is apparent and an urge to see what is the 'deeper' meaning. Suspicion is ubiquitous in everyday life. Although commonly denied, it helps us to understand the actions of others by speculating on intentions or motives. Such suspicious accounts are common in forms of gossip (Emler, 1992, Rosnow & Fine, 1976). Indeed, one could argue that a hermeneutics of suspicion is necessary in order to conduct a psychiatric diagnosis in that a diagnostician suspects a patient may have a particular disorder and asks questions oriented to this purpose -- indeed Ricoeur (1970) denotes Freud as one of the

three 'masters of suspicion' alongside Marx and Nietzsche. Writers have demonstrated how conspiratorial stances help mobilise political groups (Billig, 1991; Hofstadter, 1966; Inglehart, 1987). A broader viewpoint sees a conspiratorial or paranoid discourse as one used not only by supposedly pathological individuals but by all members of society. Once again there is no clear boundary between the normal and pathological but the simple ubiquity of suspicion does not remove the power of pathologization which derives its warrant from the excluding and dividing practices of the psy complex, notably the existence of the psychiatric category of paranoia. Once more, the single assertion of the normality of paranoia does not deconstruct the category since its power is found in the cluster of other oppositions and practices surrounding it.

IV. The reification of form over 'meaningless' content

One of the surprising things about diagnostic classification systems like the DSM-IV, ICD-10 and interview schedules like the Present State Examination (Wing, Cooper & Sartorius, 1974) is that they pay relatively little attention to the content of particular phenomena and much more to their form. These frameworks transform behaviour into symptoms which are either present or absent (Barrett, 1988). Thus what a psychiatric patient talks about in the course of a diagnostic interview becomes transformed into a 'belief' which in turn may be transformed into a 'delusion' if it meets certain criteria.

Berrios (1988) has described how the distinction between form and content, an 'anatomy-clinical view', became the dominant system in medicine during the nineteenth century. He argues that the success of this model in physical medicine may have encouraged alienists to follow suit so that by the beginning of the twentieth century,

Jaspers could assert that 'form must be kept distinct from content which may change from time to time ... it is only the form that interests us' (1963, pp.58-59). Yet psychiatry appears not to have been as successful in attempting to live up to its aspiration to mimic physical medicine. Thus, for example, the validity, etiology, prognosis and treatments of disorders like schizophrenia remain problematic (Bentall, 1990; Boyle, 1990). Indeed there are those who question whether physical medicine has been as successful as it claims. Thus Illich (1976) has argued that the rhetoric of medical science is mystificatory, much health distress is iatrogenic, leads to the medicalization of life and that the concept of cure is questionable.

By following the medical imperative, described by Foucault (1973), to seek abstract generalities and commonalities, psychiatric knowledge de-contextualizes patients' experiences, assuming that their meaning and function are not particularly relevant. Boyle (1992) has proposed that the pre-occupation with form over content derives in part from the assumption that content is meaningless when compared to clinicians', rather than patients', belief systems. She has argued that maintaining a disjuncture between form and content enables the pathologization of that which many might find 'bizarre' since this threatens the identity of the self celebrated in the DSM, the unitary rational subject (Gaines, 1992, has made a similar point).

The view that, for example, delusions are merely 'empty speech acts' (Berrios, 1991) fails to consider the range of evidence which points to their meaningfulness. Thus Roberts (1991) notes how the content of 'delusional' beliefs make sense when viewed from a stance informed by the believer's biography. Boyle (1992) has argued that

abnormal beliefs may have powerful functions for individuals including the maintenance of self-esteem (also noted by Bentall, 1994); the conferring of special status; provision of comfort; provision of guidance; and removal of responsibility for negatively judged behaviour. Indeed, even a superficial look at the content of so-called paranoid subjects in psychological research demonstrates the cultural embeddedness of these beliefs: with mentions of Royalty, the police, terrorism, the devil, doctors, God, politicians, neighbours and so on (for examples, see the case descriptions in Lyon, Kaney & Bentall, 1994).

However, the distinction between form and content breaks down since the major categorizations of delusions are made on the basis of content: delusions are denoted as grandiose, persecutory, erotomanic, jealous and somatic in DSM-IV. Once again, the attempt to suppress one side of the opposition and privilege the other does not work: the other side 'leaks' through, in this case because form is dependent on content.

Content may be transformed into numerical form (e.g. through types of content analysis) in order to allow a style of analysis which appears more scientific. I do not wish simply to privilege 'content' in a humanistic way since this simply reproduces the problem; content has to be expressed in a type of form, that is, content is always mediated by form⁷. It is not reification which is the problem - at times reification may be useful. Rather what is needed is a concept which implies both form and content. Moreover, this opposition is fixed in position with the others described here, especially the purity/messiness of pathological states.

V. The notion of a pure pathological state

The obsession with form is closely tied to the importance of abstracting the object of psychopathological discourse to the finest detail. Thus, classificatory systems imply the notion of a pure pathology, a single disease (almost a Platonic form). Foucault (1973) has described how, in the eighteenth century, medical science was transformed from being 'an uncertain kind of knowledge' through the use of the concept of probability and degrees of certainty. The imprecision of diagnosis became 'merely a void to be occupied by the technical armature of a perception of cases' (Foucault, 1973, p.99, emphasis in original). Several stages were required here: the reduction of phenomena to simple elements; use of analogy to study resemblances between phenomena; the perception of frequencies; and the calculation of degrees of certainty. The nosographic gaze thus moved from that of the gardener to that of the chemist with the object being to isolate component elements.

As with the reification of form as opposed to content, the preoccupation with pure pathology is closely allied with the desire of the psy disciplines to follow medical science in claiming the authority of the natural sciences. To discuss a pure pathology means that one does not get caught up in the inevitable bewildering complexities and ambiguities of the individual patient. Measurement of the state of the patient is thus possible. Through the use of diagnostic manuals a threshold of pathology is created, entrance to which is determined by the observation and counting of 'symptoms'. The context and content of behaviour can be left aside since 'social and cultural aspects of behaviour are much less amenable to a scientific analysis than are biological aspects' (Valentine, 1992, p.4). Moreover the ascription of a particular pathological state thus inscribes a particular clinical identity into a patient's life, the course of which may be

compared with the clinical descriptions of cases found, for example in the DSM-IV Casebook (Spitzer, Gibbon, Skodol, Williams & First, 1994).

Recently some empirical researchers have argued for research into individual symptoms (Bentall, Jackson & Pilgrim, 1988; Costello, 1992) but even here there is debate about what constitutes a symptom. Ambiguity seems to dog every attempt to denote a pure pathological state. This state of affairs brings into relief another implication of classificatory systems: that there are complex and difficult cases which require a multiplicity of similar, but different, pathological states. Thus since the publication of the first edition of the American Psychiatric Association's DSM, paranoia has endured as: (i) a category of its own, (ii) a sub-type of schizophrenia and (iii) as a sub-type of a personality disorder. Within these three broad headings however, there have been a number of definitional and typological changes. For example, the publication of DSM-III-R saw the loss of 'paranoia', 'atypical paranoia', 'shared paranoid disorder' and 'acute paranoid disorder' but saw the creation of a whole new category: 'Delusional (paranoid) disorder'. There were no further changes to the criteria in DSM-IV (although delusional disorder was brought into the section entitled 'Schizophrenia and other psychotic disorders'). The diagnostic repertoire is thus flexible enough to be both highly specific and detailed and yet also general enough to cover a number of eventualities. Such flexibility continues in the way actual criteria are used in practice. Indeed, ICD-10 notes how diagnostic guidelines are 'worded so that a degree of flexibility is retained for diagnostic decisions in clinical work' (p.1). Harper (1994a) has described how clinicians achieve such flexibility by using a number of discursive strategies in constructing a diagnosis of paranoia and in meeting challenges to such a diagnosis (e.g. the assertion

that the belief is warranted).

Clinicians often complain that their experiences of patients do not fit standard diagnostic criteria: they may have one symptom short of diagnostic fulfillment or may have symptoms which challenge definitional assumptions (Garety, 1985) or they may be complex cases with multiple symptoms which refuse to be pigeon-holed. Indeed Garety, Kuipers & Fowler (1992) have argued that current psychopathological research is deficient since it is based on the notion of a mono-symptomatic patient, few of whom exist in psychiatric services. Indeed, in clinical practice it would appear that paranoia is used alongside a variety of other diagnoses including anxiety and depression. Such a state of affairs is considered a confounding variable in traditional research and psychiatric journal editorial policies firmly police the boundary around the purity of diagnostic cases. Thus many research designs have 'groups' of patients diagnosed with schizophrenia, or depression despite the common experience of researchers that patients do not fit neatly into categories. As a result only research which separates patients on this basis gets published, maintaining the dominance of diagnostic categories. The categories are also sustained by a wide variety of interests. Kirk & Kutchins (1992) note the importance of the DSM as a money-making venture for the American Psychiatric Association and the fact that U.S. practitioners have to record a DSM diagnosis in order to be re-imbursed by insurance companies. Bentall, Jackson & Pilgrim (1988) and Boyle (1990) note other vested interests including relatives of those diagnosed mentally ill, mental health professionals and the pharmaceutical industry. Indeed, the notion of pathological classification ignores the fact that many psychiatrists diagnose not only on fulfillment of (formal and informal) diagnostic criteria but also on

the basis of drug-response.

Simply privileging messiness however, might be regarded as abnegating a responsibility to understand and would be useless without challenging the dominant poles of the other oppositions. Furthermore, the problem does not lie in the difficulty of squeezing patients' symptoms into a classificatory system, since one response to this might be in designing better nosologies (one justification for the continual revamping of diagnostic manuals). Rather, the problem lies in the very practice of diagnosis.

VI. The dominance of professional over popular, 'lay' and patient views

As with any corpus of the professional scientific literature, it has been possible in this paper to point to areas of conflict. However, there are other views which remain subjugated even here simply because of the fact that it is a professional scientific literature. Pilgrim & Rogers (1993) comment that 'clinical research in the area of mental health has tended either to exclude the views of patients or portray them as the passive objects of study' (1993, p.161). In contrast, they have argued that users of services can be seen not only as passive or absent patients but also as active consumers and survivors of the psychiatric system.

User views are not homogenous and are no more essentially 'true' than other accounts. Where they agree with dominant psychiatric views such accounts may appear in professional journals. Thus Bowden (1993) adopts a straightforwardly medical interpretation of his experiences in Schizophrenia Bulletin: 'I'm a paranoid schizophrenic. Many psychologists and psychiatrists have told me this over the years,

but I am just coming to the point where I actually believe it' (1993, p.165).

On the other hand, there are those who adopt more liberatory accounts. Thus Steiner (1971) has declared that paranoia is 'a state of heightened awareness. Most people are persecuted beyond their wildest delusions' (1971, p.282). Blaska (1992) has observed 'You can't even listen, to each other, without someone spying, reporting, recording and charting. And then calling you paranoid if you notice' (1992, pp.283-284). Chadwick has argued for a holistic understanding: 'every human being has a genetic, biochemical, physiological, emotional and motivational, cognitive, social and spiritual aspect' (1993, p.249). Autobiographical work like this gives back the legitimacy to the author's beliefs removed by professionals' accounts and allows them to reclaim more of their identity which is so often defined by professional discourse although this may prove difficult since the identities provided by dominant discourses are disempowering (Sampson, 1993). Such engagement lends credence to the view that there exists a diversity of valid explanations for such experiences encompassing not only the medical but a wide variety of others. Some professionals have developed theories which encompass such variety (Romme & Escher, 1993).

Patients' views are not the only subjugated voice in professionals' accounts. The same goes for what Pilgrim & Rogers (1993) describe as 'lay' views which they argue prefigure professional views. Indeed, Curt (1994) has noted that 'even a cursory glance through the literature of our collectivity reveals that many of the ideas that we have about madness [in general] are informed by, and inform, a rich and varied collection of presentations of the mad - in painting, photography, film, popular fiction, theatre and

song' (1994, p.151). Harper (1993) has argued that the location of paranoia as a disorder of a pathological individual ignores the vast social influence the concept of paranoia has in popular culture in books (O'Donnell, 1992), film (Barker, 1992), history (Graumann & Moscovici, 1987), politics (Billig, 1991), everyday conversation and so on.

Thus professional accounts are embedded in a deeper cultural reservoir of knowledge. Barrett (1991) has noted that, when talking about patients, professionals make use of an 'informal scheme of classifying patients based on "lay" concepts of madness' (1991, p.8). In case records, however, Barrett reported that psychiatric interview conversations were transformed through the use of 'intermediate typifications' which were 'words or phrases which bridged "lay" concepts of mental illness and "professional" concepts of schizophrenia' (1991, p.7). He has described how, in a psychiatric interview, the psychiatrist framed questions to a patient's relative, in terms of lay understandings of mental illness and pointed out that 'this tacit network of meanings underlay the intersubjective agreement shared by the participants to this interview, yet it was little evident in the written account' (1988, p.273). In Western culture, paranoia, as a short-hand description of madness serves as a way of marking out and 'cutting out' those we consider to be odd, whose behaviour can no longer be seen to be explicable according to normal social rules (Smith, 1978). Jokes, cartoons and so on concerning paranoia serve to underline such dividing and excluding practices (see Harper, 1993).

There is a great deal of commonality between 'lay' and 'professional' views. Curt (1994), discussing Gleeson's (1991) work, notes that some of the characters identified

in her Q-sorts mapped neatly onto psychiatric diagnostic categories. However, professional accounts do not simply mirror lay accounts since there is a need to demonstrate specialist expertise and the distinctive contribution they have to offer (Bowers, 1988). DSM-III-R notes 'because the ordinary English meaning of the term "paranoid" suggests only suspiciousness, the more nosologically descriptive term "Delusional Disorder" is used' (p.420).

Of course, this is not all one way traffic: Gleeson (1991) notes that instead the relationship between traditional, new and old folk beliefs and professional views is a dialectical and interactive one. However, although the distinction between them breaks down it is clear that accounts do not have equal effects, rather this varies depending both on the position of the discourse user and on the power, or dominance of a particular account. When a 'lay' person says they or their relative has 'clinical depression' rather than that they are 'fed up', we can see that there is some representational work going on in this use of a dominant psychiatric discourse. Such discourses have the effect of marking someone out as different and requiring the attentions of professional psychiatric expertise.

Deconstruction, variation and contradiction

One of the problems with traditional critiques or polemics is that they engage in what Curt (1994) has termed a 'singularizing' discourse -- a new approach to the study of an object is proposed and any contradictions or ambiguities are subjugated. I wish to avoid such an account here. In describing oppositions apparent in the concept of paranoia,

there is not an attempt merely to privilege one side over the other. Given the aesthetic and political difficulties associated with individualization, for example, some family therapists might argue for the privileging of 'the social' over 'the individual'. Such an approach, however, simply continues to fix meaning at one side and exclude the other. Rather, this deconstruction aims to get at the conceptual policing which maintains a separation between 'individual' and 'social'. Moreover, it also examines how the oppositions do not work singly but are bound together. Thus, to use family therapy again as an example, whilst it might try to point to the interpersonal nature of paranoia (e.g. Kaffman, 1981), in so doing it still privileges pathology over normality. Here, the simultaneous acceptance of one dominant opposition (pathology) whilst refusing another (individualization) compounds the problem. In contrast, it is the job of a deconstruction to thoroughly problematize all the oppositions.

Of course, in arguing that particular sides of these oppositions are dominant does not mean that the opposed pole is never heard. Indeed, discursive work demonstrates that texts are often variable, drawing on apparently contradictory discourses. Thus, for example, many of those advocating medical approaches acknowledge the socio-political context. Jellinek, one of the architects of the disease theory of alcoholism, for example, has stated 'it comes to this, that a disease is what the medical profession recognizes as such' (Jellinek, 1960, quoted in MacAndrew, 1969, p.499⁸). Similarly, Walkup (1994) and Garety (1994) have accepted the role of contingent factors in the psychiatric diagnosis of paranoia. The point is, however, that the view of diagnosis as contingent is not a dominant discourse and is rarely, if at all, publicly acknowledged. Thus the dominant image of doctors (and other health professionals) is one of objectivity. Even

here, however, there are contradictions. Thus in those criminal cases which attract media attention there is often public criticism of those psychiatrists who diagnose a defendant as not responsible for their actions, and there is acknowledgement that such judgements are not straightforwardly objective.

As Lewine (1992) has noted, anti-medical critiques do not appreciate the fact that there are wide divisions within the 'medical model' and, moreover, it is not only biological psychiatry which can be monolithic but other approaches too, for example, psycho-analysis. Thus, we could argue that it is not necessarily the model or approach which is the problem, but rather its silencing of opposing accounts. In contrast to mono-explanatory accounts, there is a need to embrace the concept of 'sympatricity'. Curt (1994) notes this term may be used to 'describe the way different discourses may co-exist and compete within a local and contingent cultural ecology of discourses' (1994, p.242). Stainton Rogers has elaborated:

Sympatric species are those that compete, within any ecosystem, for resources and ultimately for survival, but at any point in time will be seen to be co-existing and more or less equally viable. The image is of sympatric theories that operate in parallel, at one and the same time competing and co-existing.

(1991, p.7)

With regard to the concept of paranoia, a sympatric stance would enable us to open up different ways both of seeing it and not seeing it rather than attempting to explain everything with recourse to one 'theory machine' (Lee, 1994).

The merits and possibilities of a discursive account

In furthering a positive deconstruction there is a need for concepts which attempt to dissolve the boundaries between these oppositions, transforming the subjugated (and dominant) terms. I wish to argue here that adopting a discursive perspective and using a text analogy invites more creative theorizing.

Mental health is an arena of discursive encounters, as indeed is physical health (Stainton Rogers, 1991). Thinking about one's emotional state, discussing it with others, talking with one's general practitioner or other health professional are all textually constituted. Furthermore, professionals' diagnoses and treatment decision-making are discursively constructed (Barrett, 1988; Hak, 1989, 1992; Harper, 1994a; Soyland, 1994b). Moreover psychology and psychiatry are deeply metaphorical disciplines (Leary, 1990; Soyland, 1994a). Professional texts concerning paranoia are filled with metaphorical language which shape our ideas. Thus delusions are 'beliefs' which are 'fixed', 'abnormal', 'unshakeable', 'unwavering', may be 'infectious' resulting in 'delusional infestation'. Such accounts contain many examples of rhetorical moves, especially extreme case formulations, which increase the facticity of accounts (Edwards & Potter, 1992). Many categories of mental illness are well known and hence culturally available to 'lay' people (Gleeson, 1991). Thus most people would know what it is to act in a paranoid manner and so the adoption of such a stance, or, over a longer period of time, identity, is a discursive matter.

A discursive approach is attentive to such matters and enables the dissolution of the six oppositions outlined above. First, it removes a distinction between the individual and the social. So often, commentators assume that, for example, paranoia is a function of

either the individual or of their immediate social context. Using discursive notions we can see that such a diagnosis might occur because of the operation of these in a singular process of positioning. Davies & Harré (1990) assert that selves are produced discursively through subject positions which one can place oneself in but in which one is also positioned by others or by the operations of discourse. Thus a diagnosis of paranoia may occur because one is adopting such a stance and/or because others (e.g. neighbours, relatives, professionals) are positioning you that way and/or because the dominant discourses of society (e.g. proscription of suspicion versus prescription of trust) position you. One may accept or reject such an identity but this is dependent on one's position in a matrix of power. As Sampson (1993) and Soyland (1994b) have noted, the 'others' here will also position themselves and be positioned by dominant discourses (e.g. as 'concerned relatives' or 'mental health experts').

In providing a location in which one can be positioned by others, paranoia becomes a form of textual life which, when lived, has a number of effects. In the text of paranoia a number of themes recur: the imputation of intentionality; the awareness of the malevolence of others; the seeing of connections between apparently unconnected things; and the evangelical wish to convince others. Studies of the use of what has become known as the 'paranoid style' in political rhetoric highlight a number of the effects such a text may have: the provision of an account with which political groups may explain their marginalization (Hofstadter, 1966; Inglehart, 1987); the warranting of certain kinds of conduct, for example the perpetration of the holocaust (Billig, 1991); a way of unifying against an external or internal threat; and a way of creating a sense of purpose and mission, a dramatising of history where the person or group using paranoid

rhetoric becomes active, seeing a meaning in all events (Harper, 1993). Thus a discursive perspective is non-individualistic since it looks at which discourses are used, by whom, to serve what interests, and how subjects are positioned.

There is no assumption of a unitary rational as opposed to an irrational or emotional subject. Rather, there is an assumption of discursive variability (Edwards & Potter, 1992) or conflict (Hollway, 1989). The concern is to understand how and why a multiplicity of subject positions are produced rather than comparing them to idealised notions of normal belief or reality. A discursive perspective bridges the pathological/normal divide in assuming that the text of paranoia is culturally available to many rather than only to a minority of abnormal individuals - thus it focuses on discourse rather than individuals. Moreover, it focuses as much attention on the discourse and the role of others in positioning the subject as it does on that subject.

In focusing on what is actually said and on the possible functions of what is said, a discursive model avoids reifying abstract cognitive constructs (Edwards & Potter, 1992) and therefore no longer privileges form over content. A textual metaphor appreciates both the importance of 'form' and 'content'. Here, form could be understood as the discursive practices (Parker, 1992) or textual tectonics (Curt, 1994) which produce meaning. However, these forms are derived through an analysis of content -- it is the content which generates the forms. Similarly it does not allow purity to dominate messiness and complexity since it embraces the overdetermination of meaning produced by discursive variability, 'the rhetorical skirmishes of one against another; their rivalries and their allegiances; the playing out of dominance and submission' (Curt,

1994, p.12). A major part of such analyses then is the seeking out of that which is silenced and subjugated, for example the views of the users of psychiatric services and the explicit acknowledgement of the interplay between professional and popular and psychiatric service user views.

It may be useful to sketch out an example to illustrate how adopting such an approach helps in understanding how a person comes to occupy the position of the psychiatric 'paranoid' subject. As Parker (1992) has noted, social structure is a precondition for discursive positionings. Traditional psychiatric epidemiological research indicates that those diagnosed as paranoid are more likely to be poorer, be from a 'lower' social class, have less education and be immigrants than those attracting other psychiatric diagnoses (Kendler, 1982). Here then, social structure has already constrained the choice of positions open to the subject. As Sampson (1993) has pointed out, the ascription of identity in this manner is not simply mental, since the terms by which an identity is realized 'also describe the actual material realities within which those lives are lived' (1993, p.1227). Texts of suspicion circulate widely in Western culture and provide for their characters a sense of mission and purpose, a sense of unification against a perceived threat. It is no surprise perhaps that some people, particularly if their structural position offers them few other choices, may adopt such a location. They, however, might see themselves not as paranoid but, rather as persons who know what is really going on. At the same time, we exist in a panoptical culture which regulates our own and others' behaviour. This goes for suspicion as with anything else and thus those living a text of suspicion become positioned by others as paranoid. Of course, this may well happen the other way around: the subject becomes marked out, the

object of a covertly organized group (e.g. malicious gossip, jokes and so on). As a result the subject may be both positioned as paranoid (as soon as she or he comments on the situation) and may position themselves since this makes sense of a world where others really are out to get you. The position of 'paranoia' tends to be granted to those with little power such as fringe political groups or isolated individuals. Those in powerful social positions can adopt a discourse of distrust without fear of being called paranoid (at least by those who matter).

Discursivity and mental health practice

Discursive theories meet a criterion of usefulness (Misra, 1993) and social constructionist therapists are increasingly using discursive ideas, finding them both respectful to and empowering for their clients, including those who are considered to have 'long term mental health problems' for example 'schizophrenia' (Foreman & Dallos, 1992; McNamee & Gergen, 1992; Perkins & Dilks, 1992; White & Epston, 1990; White, 1989, 1991) although such work has its critics (Efran & Clarfield, 1992; Luepnitz, 1992). How is such mental health practice possible?

As a clinician I will act with someone in distress - as they and others define it. In doing this I both work within current dominant conceptions (of what constitutes psychological distress and what is appropriate conduct for a mental health professional) which are historically and culturally contingent and simultaneously try to challenge these in the manner of Sampson's (1993) tightrope walker. White (1994) has identified a number of ways in which mental health practitioners can make such challenges. First, he argues

that critical accounts of mental health practice, particularly of their history and real effects, should be pursued. Second, he suggests practitioners might take up positions 'at the margins of culture' and explore alternatives to dominant practices. Third, he proposes soliciting 'critical' feedback from persons of other cultures, races and classes. Fourth, he argues for clinicians to openly acknowledge day-to-day political dilemmas at work. Finally, he calls for imaginative use of language, especially metaphor, to 'stretch culture'.

Sampson (1993) has also argued for a dialogical view of the relationship between 'experts' and their clients. For this to be more than mere talk, however, there is a need for a powerful psychiatric service users -- or system survivors -- movement and it is likely that any progressive mental health service will either be provided by or, at least, be heavily involved with that movement. It is in diversity, both of power and of ideas, therefore, that a way forward is likely to lie. Indeed, the title of the British Hearing Voices Network's 1993 conference was 'the importance of a diversity of explanations' where biological accounts lay alongside parapsychological, spiritual and cognitive accounts (Baker, 1993).

Notes

1. The concept of 'paranoia' is placed in inverted commas at its first appearance in the text to reflect the fact that such categories are problematic.
2. Interestingly, DSM-IV, the most recent diagnostic manual from the American Psychiatric Association is accompanied with a trademark designation giving weight to

Kirk & Kutchins (1992) claim about the importance of the DSM's commercial value.

3. I am grateful to an anonymous reviewer for making this point. The use I make of the notion of discursive complexes does not imply a psychoanalytic reading in the way Parker (1994) does.

4. de Sauvages first used the term paranoia in 1759 when it was used as a general term for madness. The tying of paranoia with suspicion appears to have been made by Kahlbaum in 1863 (Rycroft, 1987). For more on the history of paranoia see Lewis (1970) and the commentary by Harper (1994b).

5. The incongruity of contradictory discourses of paranoia clashing is the source of much paranoia humour. The paranoia proto-joke 'just because I'm paranoid doesn't mean they're not out to get me' derives its funniness from the placing of one discourse (that I am paranoid, hence believing something false) alongside an opposing discourse (I am right: they are out to get me). For further discussion of paranoid humour see Harper (1993).

6. It is rarely clear what meaning the term abnormal has. If it refers only to what is statistically abnormal then clearly, as I noted above, many apparently bizarre beliefs have wide currency. Such a position, however, paradoxically strengthens the pathological assumption since it acknowledges that those at the extreme end of the normal distribution are abnormal and, hence pathological. This despite the fact that epidemiological research routinely reports on people at those extreme ends who have

not come into contact with psychiatric services and who 'recover' from states of distress without formal professional help (Goldberg & Huxley, 1992).

7. Of course content/context is another oppositional pairing which requires a deconstruction.

8. I am indebted to an anonymous reviewer for this quotation.

References

Allen, L. (1994). The politics of therapy: Michael White in conversation with Lesley Allen. Context, 18, 28-34.

American Psychiatric Association (1987). DSM-III-R: Diagnostic and statistical manual of mental disorders, 3rd rev. ed. Washington DC, USA: American Psychiatric Association.

American Psychiatric Association (1994). DSM-IVTM: Diagnostic and statistical manual of mental disorders, 4th ed. Washington DC, USA: American Psychiatric Association.

Baker, P. (1993). The British experience. In M. Romme & S. Escher, Accepting voices. London, UK: MIND.

Barker, A. (1992). Cries and whispers: What is a paranoia movie?, asks Adam Barker, looking at work from Coppola to 'JFK'. Sight and Sound, 1, 24-25.

Barrett, R.J. (1988). Clinical writing and the documentary construction of schizophrenia. Culture, Medicine and Psychiatry, 12, 265-299.

Barrett, R.J. (1991). Psychiatric practice and the definition of schizophrenia. Dulwich Centre Newsletter, 4, 5-11.

Bentall, R.P. (Ed.). (1990). Reconstructing schizophrenia. London, UK: Routledge.

Bentall, R.P. (1994). Cognitive biases and abnormal beliefs: Towards a model of persecutory delusions. In A.S. David & J. Cutting (Eds.), The neuropsychology of schizophrenia. London, UK: Lawrence Erlbaum Associates.

Bentall, R.P., Jackson, H.F. & Pilgrim, D. (1988). Abandoning the concept of 'schizophrenia': Some implications of validity arguments for psychological research into psychotic phenomena. British Journal of Clinical Psychology, 27, 303-324.

Berrios, G.E. (1988). Historical background to abnormal psychology. In E. Miller & P.J. Cooper (Eds.), Adult abnormal psychology. Edinburgh, UK: Churchill Livingstone.

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

Billig, M. (1991). Arguments in Fascist propaganda. In M. Billig, Ideology and opinions: Studies in rhetorical psychology (pp. 107-121). London, UK: Sage.

Blaska, B. (1992). What it feels like to be treated like a CMI - and 'prevail'-ing. Changes: An International Journal of Psychology and Psychotherapy, 10, 282-285.

Bowden, W.B. (1993). First person account: The onset of paranoia. Schizophrenia Bulletin, 19, 165-167.

Bowers, J. (1988). Review essay on Discourse and social psychology: Beyond attitudes and behaviour. British Journal of Social Psychology, 27, 185-192.

Boyle, M. (1990). Schizophrenia: A scientific delusion? London: Routledge.

Boyle, M. (1992). Form and content, function and meaning in the analysis of 'schizophrenic' behaviour. Clinical Psychology Forum, 47 (September), 10-15.

Boyle, M. (1994). Schizophrenia and the art of the soluble. The Psychologist: The Bulletin of the British Psychological Society, 7, 399-404.

Boyne, R. (1990). Foucault and Derrida: The other side of reason. London, UK: Unwin Hyman.

Burman, E. (1994). Deconstructing developmental psychology. London: Routledge.

Butler, R.W., & Braff, D.L. (1991). Delusions: A review and integration. Schizophrenia Bulletin, 17, 633-647.

Bynum, W.F., Porter, R. & Shepherd, M. (Eds) (1985). The anatomy of madness: Essays in the history of psychiatry, Volume 1. People and ideas. London, UK: Tavistock.

Castel, R. (1989). L'Ordre psychiatrique. Paris, France: Editions de Minuit.

Chadwick, P.K. (1992). Borderline: A psychological study of paranoia and delusional thinking. London, UK: Routledge.

Chadwick, P.K. (1993). The stepladder to the impossible: A first hand phenomenological account of a schizoaffective psychotic crisis. Journal of Mental Health, 2, 239-250.

Cohen, J.M. & Cohen, M.J. (Eds.) (1980). The Penguin dictionary of modern quotations. Second Edition. Harmondsworth, UK: Penguin.

Costello, C.G. (1992). Research on symptoms versus research on syndromes: Arguments in favour of allocating more research time to the study of symptoms. British Journal of Psychiatry, 160, 304-308.

Curt, B.C. (1994). Textuality and tectonics: Troubling social and psychological science.
Buckingham, UK: Open University Press.

Davies, B. & Harré, R. (1990). Positioning: The discursive production of selves.
Journal for the Theory of Social Behaviour, 20, 43-63.

Derrida, J. (1994). Spectres of Marx. New Left Review, 205, 31-58.

Edwards, D. & Potter, J. (1992). Discursive psychology. London, UK: Sage.

Efran, J.S. & Clarfield, L.E. (1992). Constructionist therapy: Sense and nonsense. In
S. McNamee & K.J. Gergen (Eds.), Therapy as social construction. London, UK: Sage.

Emler, N. (1992). The truth about gossip. British Psychological Society Social
Psychology Section Newsletter, 12(7), 23-37.

Enoch, M.D. & Trethowan, W. (1991). Folie à deux (et folie à plusieurs). In M.D. Enoch
& W. Trethowan, Uncommon psychiatric syndromes, 3rd ed. Oxford, UK:
Butterworth-Heinemann.

Fisher, L. (1992). Hermeneutics of suspicion and postmodern paranoia: Psychologies
of interpretation. Philosophy and Literature, 16, 106-114.

Foreman, S. & Dallos, R. (1992). Inequalities of power and sexual problems. Journal of Family Therapy, 14, 349-369.

Foucault, M. (1967). Madness and civilization: A history of insanity in the age of reason. London, UK: Tavistock.

Foucault, M. (1973). The birth of the clinic: An archaeology of medical perception. London, UK: Tavistock.

Foucault, M. (1979). Discipline and punish: The birth of the prison. London, UK: Allen Lane.

Foucault, M. (1980). Power/knowledge. Selected interviews and other writings 1972-1977. Brighton, UK: Harvester Press.

Freud, S. (1911). Psycho-analytic notes on an autobiographical account of a case of paranoia (Dementia Paranoides). In J. Strachey & A. Freud (Eds) The standard edition of the complete psychological works of Sigmund Freud, (Vol. XII, pp.3-84).

Gaines, A.D. (1992). From DSM-I to III-R; Voices of self, mastery and the other: A cultural constructivist reading of US psychiatric classification. Social Science and Medicine, 35, 3-24.

Garety, P. (1985). Delusions: Problems in definition and measurement. British Journal

of Medical Psychology, 58, 25-34.

Garety, P.A. (1994). Construction of 'paranoia': Does Harper enable voices other than his own to be heard? British Journal of Medical Psychology, 67, 145-146.

Garety, P., Kuipers, L. & Fowler, D. (1992). Cognitive behaviour therapy for psychosis. Paper presented at Psychological Treatments for Psychotic Symptoms conference. Department of Clinical Psychology, University of Liverpool, 4-5 June.

Garfinkel, H. (1984). Studies in ethnomethodology. Cambridge, UK: Polity Press.

Gergen, K.J. (1985). The social constructionist movement in modern psychology. American Psychologist, 40, 266-275.

Gleeson, K. (1991). Out of our minds: The deconstruction and reconstruction of madness. Unpublished Ph.D. thesis. Department of Psychology, University of Reading, UK.

Goldberg, D., & Huxley, P. (1992). Common mental disorders: A bio-social model. London, UK: Routledge.

Graumann, C.F., & Moscovici, S. (1987). Changing conceptions of conspiracy. New York, USA: Springer-Verlag.

Hak, T. (1989). Constructing a psychiatric case. In B. Torode (Ed), Text and talk as social practice. Dordrecht, Netherlands: Foris.

Hak, T. (1992). Psychiatric records as transformations of other texts. In G. Watson & R.M. Seiler (Eds), Text in context: Contributions to ethnomethodology. London, UK: Sage.

Harper, D.J. (1992). Defining delusion and the serving of professional interests: The case of 'paranoia'. British Journal of Medical Psychology, 65, 357-369.

Harper, D.J. (1993). Discourses of conspiracy, suspicion and mistrust: 'Paranoia' and its cultural significance. Unpublished manuscript.

Harper, D.J. (1994a). The professional construction of 'paranoia' and the discursive use of diagnostic criteria. British Journal of Medical Psychology, 67, 131-143.

Harper, D.J. (1994b). Histories of suspicion in a time of conspiracy: A reflection on Aubrey Lewis' history of paranoia. History of the Human Sciences, 7, 89-109.

Henriques, J., Hollway, W., Urwin, C., Venn, C. & V. Walkerdine (1984). Changing the subject: Psychology, social regulation and subjectivity. London, UK: Methuen.

Hingley, S.M. (1992). Psychological theories of delusional thinking: In search of integration. British Journal of Medical Psychology, 65, 347-356.

Hofstadter, R. (1966). The paranoid style in American politics and other essays. London, UK: Jonathan Cape.

Hollway, W. (1989). Subjectivity and method in psychology: Gender, meaning and science. London, UK: Sage.

Illich, I. (1976). Limits to medicine - Medical nemesis: The expropriation of health. Harmondsworth, UK: Penguin.

Inglehart, R. (1987). Extremist political positions and perceptions of conspiracy: Even paranoids have real enemies. In C.F. Graumann & S. Moscovici (Eds.), Changing conceptions of conspiracy (pp. 231-244). New York, USA: Springer-Verlag.

Jaspers, K. (1963). General psychopathology (translated by J. Hoening & M.W. Hamilton). Manchester, UK: Manchester University Press.

Jenkins, H. & Asen, K. (1992). Family therapy without the family: A framework for systemic practice. Journal of Family Therapy, 14, 1-14.

Jodelet, D. (1991). Madness and social representations. London, UK: Harvester Wheatsheaf.

Kaffman, M. (1981). Paranoid disorders: The interpersonal perspective. Journal of

Family Therapy, 3, 21-30.

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

Kirk, S.A. & Kutchins, H. (1992). The selling of DSM: The rhetoric of science in psychiatry. New York, USA: Aldine de Gruyter.

Leary, D.E. (Ed.) (1990). Metaphors in the history of psychology. New York, USA: Cambridge University Press.

Lee, N. (1994). Xenomorph vs. theory machine: Can we get by without theory. Paper presented at day conference. Discourse Unit, Manchester Metropolitan University, 21 May.

Lemert, E.M. (1962). Paranoia and the dynamics of exclusion. Sociometry, 25, 2-20.

Lewine, R. (1992). The battle over schizophrenia: Review of Reconstructing Schizophrenia. Contemporary Psychology, 37, 468-469.

Luepnitz, D.A. (1992). Nothing in common but their first names: the case of Foucault and White. Journal of Family Therapy, 14, 281-184.

Lyon, H., Kaney, S. & Bentall, R.P. (1994). The defensive function of persecutory delusions: Evidence from attribution tasks. British Journal of Psychiatry, 164, 637-646.

MacAndrew, G.C. (1969). On the notion that certain persons who are given to frequent drunkenness suffer from a disease called 'alcoholism'. In S. Plog & R. Edgerton (Eds.), Changing perspectives in mental illness. New York, USA: Holt, Rinehart & Winston.

Maher, B.A. (1988). Anomalous experience and delusional thinking: The logic of explanations. In T.F. Oltmanns & B.A. Maher (Eds), Delusional beliefs. New York, USA: Wiley.

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

Mayerhoff, D., Pelta, E., Valentino, C. & Chakos, M. (1991). Real-life basis for a patient's paranoia. American Journal of Psychiatry, 148, 682-683.

McNamee, S. & Gergen, K.J. (Eds.) (1992). Therapy as social construction. London, UK: Sage.

Méndez, C.L., Coddou, F. & Maturana, H.R. (1988). The bringing forth of pathology. Irish Journal of Psychology, 9, 144-172.

Menuck, M.N. (1992). Differentiating paranoia and legitimate fears. American Journal of Psychiatry, 149, 140-141.

Miller, P. (1986). Critiques of psychiatry and critical sociologies of madness. In P. Miller & N. Rose (Eds), The power of psychiatry. Cambridge, UK: Polity Press.

Misra, G. (1993). Psychology from a constructionist perspective: An interview with Kenneth J. Gergen. New Ideas in Psychology, 11, 399-414.

Morss, J.R. (1992). Making waves: Deconstruction and developmental psychology. Theory & Psychology, 2, 445-465.

O'Donnell, P. (1992). Engendering paranoia in contemporary narrative. Boundary 2: An International Journal of Literature and Culture, 19, 181-204.

Oltmanns, T.F., & Maher, B.A. (Eds.) (1988). Delusional beliefs. New York, USA: Wiley.

Parker, I. (1992). Discourse dynamics: Critical analysis for social and individual psychology. London, UK: Routledge.

Parker, I. (1994). Reflexive research and the grounding of analysis: Social psychology and the psy-complex. Journal of Community & Applied Social Psychology, 4, 239-252.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T. & Stowell Smith, M. (forthcoming).

Deconstructing psychopathology. London, UK: Sage.

Parker, I., & Shotter, J. (Eds.). (1990). Deconstructing social psychology. London, UK: Routledge.

Perkins, R. & Dilks, S. (1992). Worlds apart: working with severely socially disabled people. Journal of Mental Health, 1, 3-17.

Pilgrim, D. (1990). Competing histories of madness: Some implications for modern psychiatry. In R.P. Bentall (Ed.), Reconstructing schizophrenia. London, UK: Routledge.

Pilgrim, D., & Rogers, A. (1993). A sociology of mental health and illness. Buckingham, UK: Open University Press.

Ricoeur, P. (1970). Freud and philosophy: An essay on interpretation. London, UK: Yale University Press.

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

Romme, M. & Escher, S. (1993). Accepting voices. London, UK: MIND.

Rose, N. (1985). The psychological complex. London, UK: Routledge & Kegan Paul.

Rose, N. (1989). Governing the soul: Technologies of human subjectivity. London, UK: Routledge.

Rose, N. (1990). Psychology as a 'social' science. In I. Parker & J. Shotter (Eds.), Deconstructing social psychology. London, UK: Routledge.

Rosnow, R.L. & Fine, G.L. (1976). Rumor and gossip: The social psychology of hearsay. New York, USA: Elsevier.

Rycroft, C. (1987). Paranoia. In R.L. Gregory (Ed) The Oxford companion to the mind. Oxford, UK: Oxford University Press.

Sampson, E.E. (1993). Identity politics: Challenges to psychology's understanding. American Psychologist, 48, 1219-1230.

Sass, L.A. (1987). Schreber's panopticism: Psychosis and the modern soul. Social Research, 54, 101-147.

Scheff, T.J. (1963). The role of the mentally ill and the dynamics of mental disorder: A research framework. Sociometry, 26, 436-453.

Schuetz, A. (1943). The problem of rationality in the social world. Economica, 10,

130-149.

Smail, D.J. (1984). Illusion and reality: The meaning of anxiety. London, UK: Dent.

Smail, D.J. (1987). Taking care: An alternative to therapy. London, UK: Dent.

Smith, D.E. (1978). K is mentally ill: The anatomy of a factual account. Sociology, 12, 23-53.

Social Surveys/Gallup Poll Ltd. (1993). Paranormal behaviour. Gallup Political Index, 393, 24-5.

Soyland, A.J. (1994a). Psychology as metaphor. London, UK: Sage.

Soyland, A.J. (1994b). Functions of the psychiatric case summary. Text, 14, 113-140.

Spitzer, R.L., Gibbon, M., Skodol, A.E., Williams, J.B.W. & First, M.B. (1994). DSM-IV casebook. Washington DC, USA: American Psychiatric Association.

Spivak, G.C. (1990). Gayatri Chakravorty Spivak: An interview. Radical Philosophy, 54, 32-34.

Stainton Rogers, W. (1991). Explaining health and illness: An exploration of diversity. London, UK: Harvester Wheatsheaf.

Steiner, C. (1971) Radical psychiatry manifesto. In J. Agel (Ed.), The radical therapist. New York, USA: Ballantine Books.

Stenner, P. & Eccleston, C. (1994). On the textuality of being: Towards an invigorated social constructionism. Theory & Psychology, 4, 85-103.

Valentine, E.R. (1992). Conceptual issues in psychology, 2nd ed. London, UK: George Allen & Unwin.

Walkup, J. (1994). Commentary on Harper, 'the professional construction of paranoia and the discursive use of diagnostic criteria'. British Journal of Medical Psychology, 67, 147-151.

White, M. (1989). Family therapy and schizophrenia: Addressing the 'in-the-corner' lifestyle. In M. White, Selected papers. Adelaide, Australia: Dulwich Centre Publications.

White, M. (1991). Deconstruction and therapy. Dulwich Centre Newsletter, 3, 21-40.

White, M. & Epston, D. (1990). Narrative means to therapeutic ends. London, UK: Norton.

Wing, J.K., Cooper, J.E. & Sartorius, N. (1974). Measurement and classification of psychiatric symptoms. London, UK: Cambridge University Press.

Winters, K.C., & Neale, J.M. (1983). Delusions and delusional thinking in psychotics: A review of the literature. Clinical Psychology Review, 3, 227-253.

World Health Organization (1992). The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines. Geneva, Switzerland: World Health Organization.

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