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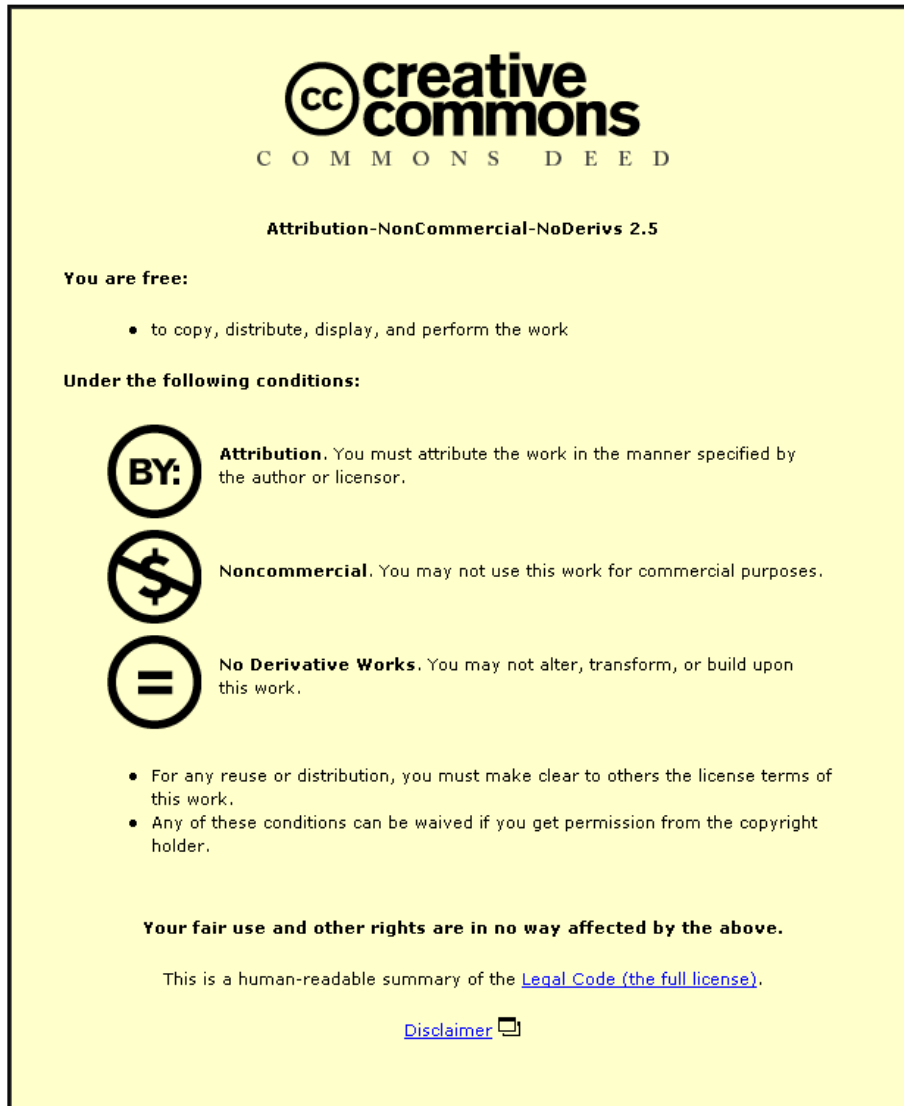
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Paranoia: a social account

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Abstract:

Both psychology and psychiatry are dominated by individualistic accounts of paranoia (and indeed, other forms of distress). As a corrective to these, this paper provides a social account of paranoia grounded in a minimal notion of embodied subjectivity constituted from the interpenetration of feelings, perception and discourse. Paranoia is conceptualised as a mode or tendency within embodied subjectivity, co-constituted in the dialectical associations between subjectivity and relational, social and material influences. Relevant psychiatric and psychological literature is briefly reviewed; relational, social structural and material influences upon paranoia are described; and some implications of this account for research and intervention are highlighted.

Introduction

Paranoia can be defined as a way of perceiving and relating to other people and to the world that is characterized by some degree of suspicion, mistrust, or hostility. It is usually understood to exist on a continuum, so that degrees of paranoia inhabit many everyday social relations. When it reaches the level where a person may encounter psychiatry, paranoia is frequently characterized by complex, self-insulating conspiratorial belief systems, distorted perceptions, and high levels of distress. In this paper we treat paranoia as a socially and materially co-constituted mode of, or tendency within, embodied subjectivity. We understand it as a way of being in the world, manifested differentially according to changing social, cultural and material circumstances and the specifics of life trajectories. Relational influences, social structures and material environments therefore play a constitutive role in our account, rather than being merely supplementary or contextual. We not only recognise that paranoia is socially constructed (Heise, 1988), we also recognise that it is relationally, societally and materially *co-constituted*: in this way we avoid the extreme relativism of some constructionist accounts, and are able to address paranoia not only as a discursive form or rhetorical resource but as a complex lived experience constituted from multiple lines of influence.

In order to offer an appropriately social account of paranoia we locate its origins and maintenance in the dialectical interpenetration of subjectivity and world, rather than within the faulty cognitions or pathological brains of individuals. This allows us to acknowledge that paranoia can be both dysfunctional and distressing, whilst not reifying it as an organic pathology. Although we recognise that brain features (neurotransmitter excesses, hormonal imbalances, increased density of dopamine receptors, etc.) may be correlated with distress, we reject the reductionist view that these are simply *causal* of paranoia. Instead, our account locates such features within the homeodynamic flux of material forces and social relations that not only co-constitutes subjectivity but also, simultaneously and relatedly, has an ongoing influence on the character of the body-brain system. The structure and chemistry of the brain are somewhat plastic, capable of being influenced by experience, habit, and repetition. Unremarkable activities such as taxi driving (Maguire et al., 2000) and piano playing (Bangert & Altenmueller, 2003) cause measurable change in brain structures, whilst clinical research has shown that decreased hippocampal volume may be associated with combat-related post-traumatic stress (Bremner et al., 1995), and that just 12 weeks of cognitive therapy causes significant changes to patterns of brain activation (Wykes & Brammer, 2002). Similarly, work with animals has shown that changes in social status impact causally on levels of the neurotransmitter serotonin (Raleigh, McGuire, Brammer, & Yuwiler, 1984), and that stressful situations increase levels of dopamine

(Weiss, Glazer, & Pohoresky, 1976). Such evidence challenges the notion that biology is simply foundational and demonstrates the poverty of dualist, reductionist explanations. It implies that we should adopt a position similar to that held by Rose when he says: “Organisms – any organism, even the seemingly simplest – and the environment – all relevant aspects of it – interpenetrate. Abstracting an organism from its environment, ignoring this dialectic of interpenetration, is a reductionist step which methodology may demand but which will always mislead” (Rose, 1997 p.140). In an academic and cultural context where dualism and reductionism are frequently presupposed, it can be difficult to convey this more dynamic and interactional view of the relationship between social and neural realms. In this paper, we attempt to do so in part by interweaving discussion of neural systems with discussion of social factors, since the more usual practice of describing these separately is too easily misinterpreted as a move towards foundationalism, and too frequently misread as endorsing the claim that neural systems are simply causal of experience.

Our inclusion of relational, societal and material influences allows us to acknowledge that the extremes of paranoia can be both distressing and unusual, without necessarily casting them as inexplicable. We propose that even these extremes become potentially sensible within the complex, synergistic interactions of relational, social and material influences, and that the social, psychological and neural processes that generate them are for the most part those that are productive of paranoia across the continuum. This is not to say that states of extreme paranoia are not striking and remarkable: our aim is not to normalise such experiences as merely commonsensical; rather, to challenge the notion that people experiencing these extremes are somehow intrinsically different to others.

In what follows, we first review some relevant psychiatric and clinical psychological literature. We then offer an account of paranoia grounded in a minimal notion of embodied subjectivity constituted jointly from discourse, perception and feelings. We show how this grounding enables meaningful associations to be drawn between social structures and relations, material conditions and paranoia, and briefly discuss some of the implications of this for research and intervention.

Paranoia, psychiatry and clinical psychology

In psychiatry, paranoia is typically understood as a symptom rather than an experience to be considered on its own terms. It is frequently associated with schizophrenia, delusional disorder and paranoid personality disorder, but may also be related to diagnoses such as depression and anxiety (American Psychiatric Association, 1994). It is assumed in psychiatry that experiences of paranoia are clearly distinguishable and separate from everyday states of being, and that they are false or irrational, the effects of some underlying pathology: accordingly, their context is regarded as relatively irrelevant and their content as largely meaningless (Harper, 1996, 2004). In accord with these assumptions psychiatry frequently searches for the causes of paranoia within the brain-body systems of individuals, an orientation simultaneously reflecting its medical basis, its longstanding preference for biological explanations (Moncrieff & Crawford, 2001) and its interdependent relationship with the pharmaceutical industry (Healy, 1997). Psychiatric research has uncovered some suggestive associations, for example between schizophrenia diagnoses and both enlargement of the ventricles and over-activity of dopamine systems in the midbrain (the ‘dopamine hypothesis’), but questions persist. The control groups for these studies are sometimes inadequate, and medication and its effects are not always ruled out. Moreover, neither of these associations are necessary or sufficient for a diagnosis of schizophrenia, and neither seems to be related to it exclusively (Thomas, 1997). Amongst others, (Bentall, 2003) suggests that excesses of dopamine might simply be indicative of states

of extreme arousal, whilst ventricular enlargement may be caused by medication.

Moreover, there are grounds for rejecting each of psychiatry's core assumptions regarding paranoia. As with other categories of delusions, these assumptions are that the beliefs are false; idiosyncratic (not shared by other community members); and held with unwavering conviction. Beginning with falsity, psychiatry typically adopts a naively realist stance towards paranoia, claiming to judge the veracity of beliefs according to the evidence accompanying them. However, despite its realist claims, in practice diagnosis of delusions rarely involves empirical investigation. Instead, Maher has argued that assessment of the plausibility of 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' (Maher, 1992 p.261), a claim backed up by evidence from observation of psychiatric consultations (McCabe, Heath, Burns, & Priebe, 2002). The idiosyncrasy of beliefs is challenged by evidence that irrational beliefs are highly prevalent in our culture – for example, with respect to the supernatural - and that "everyday" suspicion and mistrust are also more prevalent than might be expected (Social Surveys/Gallup Poll Ltd., 1995). Delusional beliefs too, even at levels of clinical significance, are more common amongst the general population than psychiatry presupposes (e.g. Poulton et al., 2000; van Os, Hanssen, Bijl, & Ravelli, 2000). Lastly, the notion of unwavering conviction of delusions is refuted by research demonstrating that conviction varies over time and across contexts (Garety, 1985). The dimensions which seem to differentiate between those who do not enter mental health services and those who do are not their beliefs *per se* but the levels of distress and preoccupation associated with them (Peters, Joseph, Day, & Garety, 2004). Moreover, although psychiatry typically treats the content of paranoid beliefs as meaningless, they often relate to purpose and meaning in a person's life and can be associated with life experience (Rhodes & Jakes, 2000) or wider societal influences (Mirowsky & Ross, 1983).

Critics of psychiatry encounter a dilemma when wishing to comment on links between the environment and distress, since the vast majority of relevant research depends upon psychiatric nosologies. Therefore, reference to these studies is not an endorsement of psychiatry, merely recognition that this epidemiological evidence is all that there is (Rogers & Pilgrim, 2003). With this in mind, epidemiological research clearly shows that paranoia is related to social and material conditions. A recent review of studies from the UK, USA, Canada, Australia and the Netherlands associated overall psychiatric morbidity with markers of inequality such as unemployment, low income and impoverished education (Melzer, Fryers, & Jenkins, 2004). People with a diagnosis of schizophrenia often have paranoid experiences, and there is a relationship between schizophrenia diagnoses and social inequality (Croudace, Bloom, Jones, & Harrison, 2000; Eaton & Harrison, 2001). It is sometimes claimed that this relationship is caused by social selection and 'urban drift' i.e. people become poorer and move to deprived inner-city areas because they get ill. This claim is contradicted by longitudinal research showing that people whose fathers had occupied low socio-economic status and who were born in a deprived area were 8.1 times more likely to attract a diagnosis of schizophrenia as adults, compared to case-controls from the birth register (Harrison, Gunnell, Glazebrook, Page, & Kwiecinski, 2001). Independently of income inequality there is a relationship between minority ethnic status and schizophrenia diagnosis: black and Asian people in the UK, for example, are 50% more likely to be diagnosed than white people (King, Coker, Leavey, Hoare, & Johnson-Sabine, 1994). Genetic explanations for this imbalance are sometimes suggested but evidence here is both unconvincing (Sharpley, Hutchinson, & Murray, 2001) and rendered implausible by studies showing that the prevalence of schizophrenia diagnoses is higher among black people living in majority white areas (Boydell et al 2000). Other studies have shown that paranoia is associated with immigration and low socio-economic status (Kendler, 1982), refugee status (Westermeyer, 1989), victimisation and stressful life events (Johns et al., 2004). There is also

evidence that paranoia is associated with maleness, both in the general population (Johns et al., 2004) and in clinical samples, where for example paranoid and other core schizophrenia diagnoses are 7.5 times more likely to be applied to men than women (Scully et al., 2002)

In contrast to psychiatry, in recent years British clinical (predominantly cognitive) psychologists have conducted innovative research focusing on particular kinds of homogeneous psychotic experience (unusual beliefs, hearing voices) rather than heterogeneous diagnostic categories (e.g. schizophrenia). These researchers treat paranoia and its components (such as delusional beliefs, information processing biases, attributional styles and beliefs about self, world and other) as problems in their own right. Much of this work is focused specifically on delusional beliefs, and Garety & Freeman (1999) identify four explanatory models: delusions as explanations of unusual perceptual phenomena; delusions as a theory of mind deficit; delusions as a sign of problems with probabilistic reasoning; and delusions as a defence. Here we will focus on the last two of these models, since they have provided the most sustained focus of research in recent years.

In the model put forward by Bentall, Kinderman, & Kaney (1994), delusional beliefs serve a defensive function and blaming others for negative events prevents low self-esteem thoughts from reaching consciousness. Individuals have 'latent negative self representations or schemata' – covert low self esteem – which is pushed out of awareness by making external, negative attributions that prevent the discrepancy between self presentation and self-ideals from becoming obvious. This model has since been revised to emphasise a cycle between attributions and self-representations, where attributions influence self-representations which, in turn, influence future attributions (Bentall, Corcoran, Howard, Blackwood, & Kinderman, 2001). In this revised model self esteem may be more variable, and linked to persecutory delusions in a more dynamic fashion. The alternative model (Freeman, Garety, Kuipers, Fowler, & Bebbington, 2002) developed from a concern with problems in probabilistic reasoning, and proposes that rather than serving a defensive function delusional beliefs directly represent the person's experience, in particular their emotional state. Hence, in this model it is not necessary for individuals to have covert low self esteem, although they may well make external negative attributions in order to minimize their distress. Both models also reference other cognitive elements and processes, but differ with regard to the hypothesized character and function of delusional beliefs and their relationship with self esteem. Numerous published studies elaborate, test and compare aspects of these models, for example with regard to the role played by theory of mind deficits (Taylor & Kinderman, 2002); the stability of attributional style (Bentall & Kaney, 2005); or the failure to generate more conventional accounts of experience (Freeman et al., 2004).

Within these models and elsewhere, issues of emotion and selfhood are frequently discussed. Links have been made between paranoia and self-awareness: in one experimental study a measure of 'public self consciousness' correlated with scores on a measure of paranoia; in another, people scoring higher on a paranoia scale were more susceptible to the effect of an experimental manipulation using a mirror to generate an awareness of being watched (Fenigstein & Vanable, 1992). Trower & Chadwick (1995) explicitly link shame, selfhood and paranoia in their proposal that some individuals may experience a 'bad me' paranoia characterized by feelings of worthlessness and beliefs that they are being deservedly punished for past misdemeanours. This 'bad me' paranoia should be relatively common, although a recent study suggests that, at least in early psychosis, this is not the case (Fornells-Ambrojo & Garety, 2005). Studies have also focused on emotional perception in paranoia and its relationship to communication. One study of incongruent affective communication (i.e. where verbal and non-verbal meanings do not match) found that, compared to healthy controls, people with a

diagnosis of paranoid schizophrenia were more likely to resolve incongruity with reference to the verbal content of messages, whereas controls were more likely to resolve ambiguity with reference to the affective, non-verbal content (Davis & Stewart, 2001). Another study (Combs, Michael, & Penn, 2006) found a relationship between paranoia and emotion perception, and showed that people with clinical levels of paranoia had a reduced ability to recognise negative emotion.

Four points can be drawn from this review of the literature. First, although the importance of communication is recognized, the inherently relational dimension of paranoia is inadequately considered. For example, Freeman et al. (2002) very briefly mention social isolation in relation to the development of persecutory delusions, although only in association with supposed individual tendencies to “be secretive or mistrustful .. or believe that personal matters should not be discussed with others (Freeman et al., 2002 p.336). Similarly, they conclude a lengthy list of internal, cognitive processes that may help to maintain delusions with the cursory statement that: “Finally, the person’s interactions with others may become disturbed. The person may act upon their delusion in a way that elicits hostility or isolation” (Freeman et al., 2002 p.338). In such ways, relational influence is both acknowledged and constrained, relegated to a subordinate position where causal primacy is granted to cognitive processes. Likewise, Bentall & Kaney (2005) discuss the attribution-self representation cycle in ways that rhetorically downplay relational influence, deploying a cognitive language of ‘pessimistic attributions’ and ‘changing beliefs about the self’ that seemingly arise and interact with little reference to factors external to the person. There is insufficient acknowledgement here that what we say about our selves and our world influences how others respond to us, and this in turn influences how we think and feel. Relational influences are frequently translated into internal, computational ones, or described with little reference to the material conditions and social structures by which they are mediated. More generally, relationality is obfuscated through psychology’s preoccupation with the individual and relative neglect of the responses of others involved in interaction (Georgaca, 2004; Harper, 2004), a stance that ignores how people experiencing paranoia may be subject to reactions of others that could be viewed as conspiratorial (Lemert, 1962).

Second, although emotion is obviously important in paranoia its precise contribution remains somewhat unclear. Freeman et al. (2002 p.335) propose that “Anxiety is.. the key emotion with regard to the formation of persecutory delusions”, although they acknowledge that other emotions (depression, anger, elation) influence delusional contents. Trower & Chadwick (1995) particularly emphasise the contribution of shame, whilst anger is also said to be especially problematic (Combs et al., 2006). Other studies mention feelings of threat (Taylor & Kinderman, 2002), worthlessness, disapproval, humiliation, entrapment (Fornells-Ambrojo & Garety, 2005) helplessness and powerlessness (Fornells-Ambrojo & Garety, 2005; Ross, Mirowsky, & Pribesh, 2001). Whilst there are clearly significant areas of overlap between the emotions posited as important, problems nevertheless remain. For one, some of these feelings (e.g. threat, disapproval, powerlessness) cannot be straightforwardly conceived of as *emotions* according to most commonly accepted definitions of that term (Griffiths, 1998); for another, there is no account either of the variety of feelings related to paranoia, or of the ways in which they may be related.

Third, the psychological literature on paranoia presents it as a largely disembodied condition in the sense that few links are suggested between cognitive processes and neural, physiological and other bodily processes. Accounts emphasise the influence and interaction of cognitive elements (such as attributions and self-representations), conceptualised as informational in character and related to each other in mechanistic ways. Further, whilst the role of feelings and emotions in paranoia is acknowledged, and indeed frequently central, their embodiment is largely

disregarded. Feelings and emotions are enabled and constituted by neural systems spread across multiple areas including brainstem, amygdala, hypothalamus and limbic region (Panksepp, 1998), ventro-medial prefrontal cortex, insula and cingulate (Damasio, 1994), whilst some emotional states are associated with differential patterns of hemispheric activation (Davidson, Jackson, & Kalin, 2000). However, psychology makes few attempts to associate these neural systems, or any other embodied aspects of emotion (increased heart rate, vascular constriction or dilation, pupillary changes, autonomic nervous system responses, changes in facial expression, posture and comportment etc.) with its cognitive accounts of paranoia. By contrast, although the psychiatric literature suggests some links between neural development and paranoia, these are relatively under developed and in any case predicated upon impoverished notions of social influence and problematic psychiatric categories. So paranoia frequently appears as thoroughly disembodied, and even where it is not disembodied it is nevertheless insufficiently social.

Fourth, neither the psychological nor the psychiatric literature on paranoia makes adequate reference to material and social structural influences. Psychology simply subordinates these influences to cognitive processes, following the dictum that problems “follow from people’s perceptions and evaluations of the events in their lives rather than from the events themselves” (Brewin, 1988 p.5). Because its medical roots include epidemiology, psychiatry has been somewhat better at recognising the relationships between paranoia, social structures and material conditions. Simultaneously, however, psychiatry is relatively handicapped in its attempts to convincingly *explain* these epidemiological associations: the heterogeneity and unreliability of psychiatric diagnosis problematises the identification of meaningful associations, whilst the emphasis on organic pathologies simply omits many of the social, relational and material factors that may be significant. The nature and extent of this omission is illustrated by sociological research demonstrating links between paranoia and such factors as low socio-economic status, alienated labour, exploitation, victimisation, community mistrust and widespread neighbourhood disorder (Mirowsky & Ross, 1983; Ross et al., 2001). So both psychiatry and clinical psychology, albeit in different ways, individualise paranoia. Their focus on cognitive processes and organic deficits mystifies material and social structural influence, and obscures the ways in which degrees of suspicion and mistrust, for example, may be functional in some environments.

Consequently, clinical paranoia tends to appear as the bizarre, dysfunctional behaviour of deviant individuals, rather than an understandable response to particularly toxic combinations of material circumstances, social trajectories and life events (cf. Smail, 1984, 1993). Below, we provide an account of paranoia that might address some of these issues. We begin by positing a minimal notion of embodied subjectivity constituted from the interpenetration of discourse, feelings and perception, within which feelings remain the default mode of our being. We then relate this notion of subjectivity to some of the relational dynamics which might be important in the ontogenesis of paranoia: in this, we follow the literature reviewed above and pay particular attention to feelings such as anxiety or fear, shame and anger. We then situate these relational dynamics within material environments and social structures, describing how each might amplify the effects of the other.

Paranoia and subjectivity

Our account of paranoia rests upon a minimal notion of embodied subjectivity constituted on the one hand from the dialectical interaction of socialized feelings and discourse, and on the other hand from their penetration of, and interpenetration by, external stimuli. By this, we mean not just that we can comment verbally on, or feel moved by, aspects of our world: we also mean that

the way that we feel influences the way that we experience the stimuli that make up our world.

By discourse we mean both external, spoken formulations, and inner speech. Inner speech consists of truncated fragments of external, spoken speech that have been abbreviated and stripped of predicatives. The experience of inner speech is private and personal, but its origins and content are therefore social and relational, and can frequently be traced back to instructional episodes (Shotter, 1993a). Inner speech is called out within subjectivity in response to experience, and helps to monitor and guide activity by means of internal dialogues that mirror the conversational forms of previous social interactions (Vygotsky, 1962). Inner speech is important to cognition, most obviously with respect to the meta-cognitive monitoring and organization of activity, and can be linked to lines of socio-cultural development. Here, whilst inner speech does contribute to the formation of meaning, meaning is also derived from the relationally and materially situated socialized body, constituted experientially in the form of feelings.

Although in everyday life the terms are usually interchangeable, in our account feelings are not the same as emotions. Feelings here fall into three overlapping types: they consist of the somatic component of emotion, extra-emotional feelings such as hunger, pain and sexual desire, and the subtler relational feelings of knowing that John Shotter calls “knowing of the third kind” (Shotter, 1993c). All three kinds of feeling are socialized: evidence for this comes from neuroscience (Damasio, 1994); anthropology (Shweder, 2004); sociology and social theory (Bourdieu, 1977; Charlesworth, 1999; Elias, 1978); and psychology (Benson, 2001; Ginsburg & Harrington, 1996; Ratner, 2000). Because feelings are fundamentally non-verbal and non-representational their meaning is not wholly transparent, so we must frequently engage in interpretation to establish precisely how we feel, and why. In these interpretations, the hybrid, overlapping character of feelings can lead us astray: irritability might be a measured response to the unreasonable actions of others, or it might be due to low blood sugar, tiredness, or some mixture of these. Moreover, feelings of all kinds are continually open to social and other influences, and so can be vacillating, mixed or confused (Sullivan & Strongman, 2003). Sometimes we may fail to notice or recognise what prompted a particular feeling, and so our interpretation of it may be erroneous. Further, we often have reason to disavow our feelings: to endure a job we dislike, avoid hurt to a loved one, or protect ourselves against understandings too difficult to contemplate. And in any case, much of what we feel is subtended by neural mechanisms that, whilst fundamental to consciousness, nevertheless operate outside of awareness (Damasio, 2003).

Socialised feelings and discourse come together to *co-constitute* embodied subjectivity in the moment-by-moment flow of interaction, where both are prompted and called out by our material and relational position. Feelings endow our actions and talk with motives, valences and meanings, whilst discourse temporarily ‘fixes’ the flow of socialised feeling, rendering it available for representation to self and others. In subjectivity there is a constant iteration between socialised feelings and socially-derived inner speech, a dialectical relationship, a ceaseless flux of fluid movement from one to the other (dialectical, here, means a continual transformative movement between the two, rather than their turbulent dichotomous opposition). Each informs and influences the other, and each can come to stand for, or even become, the other because, as the term ‘dialectical’ suggests, the relations between feelings and discourse are fluid, mobile and transformative. What was a largely conceptual understanding carried in discourse can, over time, become more feelingful: for example, a rejection of the free market economics of the 1980s, which at the time was constituted of various critiques regarding its impact upon communities, industry or the public services, might now be experienced as feelings of dislike toward Margaret Thatcher. Conversely, an initial feeling of unease,

discomfort or irritation with respect to a person or situation can subsequently be articulated, elaborated and eventually fixed discursively (through inner speech, conversation or both) such that we eventually 'know' and can say what is it that made us uncomfortable.

So we establish the comprehensive meaning of what we feel through its dialectical realization in language, and at the same time our speech gains force, motive and direction from the embodied feelings that carry and inhabit it. Speech, both inner and external, is already feelingful, just as, by the time we can turn around and reflect upon them, feelings are already shaped by the discourses we use to fix and render them available for inspection. Nevertheless, the dialectic between feeling and discourse is an imbalanced one in the sense that feelings remain the *default* mode of our being in the world, they supply the primordial stuff from which experience is socially co-constituted (Cromby 2007a, b). The lived, dynamic body creates meaning through sign systems what are corporeal, haptic, kinaesthetic and sensual. Unlike language, these systems constitute meaning somatically rather than by reference to social convention (Ruthrof, 1997), but these meanings interpenetrate the linguistic - indeed, they provide its constitutive preconditions (c.f. Baerveldt & Voestermans, 2005). So except when we deliberately strive to be otherwise, or when immediate situational demands require us to adopt an explicitly discursive rationality, we engage with our worlds in a predominantly feelingful manner. This might seem improbable to those readers whose academic training has rendered them professionally alexithymic, but evidence and arguments suggesting that feelings are the default mode of human being can be found in neuroscience (Damasio, 1999), anthropology (Shweder, 2004), cognitive psychology (Zajonc, 1980, 1984) and most schools of psychoanalysis (Mitchell & Black, 1995).

So the continual, flowing, dialectical interpenetration of feelings and inner speech is what most fundamentally constitutes embodied subjectivity - but this dialectic does not occur in a solipsistic vacuum. Modes of embodied subjectivity are themselves interpellated within trajectories of social participation, in a further dialectic where how we feel and what we say simultaneously realises, constitutes and transforms our social and relational position. Moreover, just as there is an interpenetrative relationship between inner speech and feelings, so there are similar relationships between how we feel and the world we occupy. As Merleau-Ponty shows, the body is not just another object in the world, it is the medium by which there is a world for us at all: consequently our embodied experience does not give us a mere *version* of the world - it gives us the world itself (Baerveldt & Voestermans, 2005). The meanings and perceptions we experience are intimately bound up with the bodily activities and functions that helped to produce them, so it follows that our world is one that is always already inhabited by embodied feelings that give it meaning: "The light of a candle changes its appearance for a child when, after a burn, it stops attracting the child's hand and becomes quite literally repulsive. Vision is already inhabited by a meaning (sens) which gives it a function in the spectacle of the world and in our existence" (Merleau-Ponty, 2002 p.60).

Thus, what we see is not simply 'out there' in the world, since what is 'out there' both co-constitutes, and is simultaneously co-constituted by, what is 'in here'. Our perceptions are a matter not just of materiality and its associated sense data, but also of the feelingful, intentional stances with which these data are continually imbued. People in love view the world through rose-tinted spectacles whilst those in the throes of misery see it in shades of grey, but this pathetic fallacy is no mere literary device: it also indexes the ways in which feelingful meanings, realised through the body, continually inhabit perception. Feelings predispose us to perceive some things rather than others, to attend to some things more than others, and to interpret what we see in particular ways. Experimental evidence for this can be found in studies which show that bank notes look bigger to poorer people (Bruner & Goodman, 1947), spiders

are more noticeable to those already frightened of them (Ohman, Flykt, & Esteves, 2001), and that our own bodies appear larger to those of us with eating disorders (Jansen, Smeets, Martijn, & Nederkoorn, 2006). In the clinical realm, the perceptions and evaluations of people with a diagnosis of depression are typically less positive than controls and frequently characterized by a triad of negative views regarding self, world and future (Beck, 1967). With regard to paranoia (Freeman et al., 2002 p.340) make a similar point, noting that “Negative beliefs about the self, others and the world, which are associated with emotional distress, influence, and are reflected in, the contents of delusions”. In short, we don't just experience a world: we experience a world suffused by the materially and socially shaped anxieties, hopes, fears and desires that currently co-constitute our subjectivity.

With regard to reasoning and decision-making, however, feelings may have a different kind of influence. Damasio's (1994) 'somatic marker' hypothesis proposes that our memories include not just perceptual information about events and situations, but also the feelings or body-state profiles which accompanied them. On future occasions when these memories become relevant, the feelings that accompanied them get fleetingly re-constituted in feedback loops between brain and body. These 'somatic markers' feed forward into decision-making by supplying valences which mark options as more or less positive or negative, according to previous experience. Unpleasant or negative feelings have the effect of both directing attention away from objects, events and situations with which they are associated and making them appear undesirable; positive feelings do the opposite, encouraging both lengthier engagement and a more favourable assessment. Although many areas of the brain might assist in the generation of somatic markers, the ventromedial prefrontal cortex and areas of the insula, cingulate and sensori-motor cortexes are frequently involved (Damasio, 1994).

Two aspects of this hypothesis must be emphasized. First, that these brain circuits are not 'the brain's decision-making system', since decision making is not only spread across the entire brain, but is a quality of persons, not brains (Bennett & Hacker, 2003) and arises in the transactions between persons and their situations, not simply within their brains. So somatic markers can simplify and accelerate decision making, but cannot themselves decide anything. Second, somatic markers are socially, relationally acquired in the course of experience: although their neural basis is in the machinery that enables homeodynamics, their particular character reflects both the specifics of individual experience and the (sub)cultural norms within which that experience occurred. As Damasio puts it: "Somatic markers are thus acquired by experience, under the control of an internal preference system and under the influence of an external set of circumstances which include not only entities and events with which the organism must interact, but also social conventions and ethical rules" (Damasio, 1994 p.179). With regard to paranoia, such experiences might include poor attachment with caregivers, bullying, and other forms of victimisation, whilst relevant social conventions might include normative assumptions of prejudice, difference and inequality.

The literature suggests that fear and anxiety figure prominently in paranoia although the somatic marker system by itself seems unlikely to enable these feelings, for which lateral and central nuclei of the amygdala, the ventral-anterior and medial hypothalamus and parts of the periaqueductal gray appear particularly important (Le Doux, 2000; Panksepp, 1998). Nevertheless, through its connections with these brain regions the somatic marker system might serve to call out feelings of fear and anxiety, and may also evoke neural images of them through the operation of what (Damasio, 1994) calls the 'as-if body' loop. Accordingly, it might be involved both in propitiating experiences of fear and anxiety, and in the creation of habits that structure activity in anticipatory avoidance of them. Simultaneously, the hypothesis implies that efforts to recognize the origins of these feelings will tend to be somewhat comprised, because they will

act as negative somatic markers for the habits, events, people and situations with which they are associated. Consequently, people may tend to orient away from them, to prefer not to talk or think about them: making it likely that they will produce discursive accounts that disavow their anxiety, or attribute it to other causes or objects.

This neural bias may be further accentuated for many individuals by feelings of shame. Shame is a complex emotion tied to the specifics of social relations, serving to signal that something is in need of repair in our standing with others. Its particular complexity arises in part from the fact that, unlike most other emotions, its object is the self in relation to others. Consequently, we understand our own shame to the limited extent that we understand ourselves and our relationships. There is frequently a reflexive dimension to feelings of shame, since shame *itself* may be both shaming and shameful – especially for men in our culture, for whom subcultural norms prohibit the expression of shame and favour proud, self-aggrandising modes of presentation. Shame may be a prominent component of many states of distress (Kaufman, 1991), and its specific relevance to some forms of paranoia has been emphasized by Trower & Chadwick (1995). In a detailed study of a corpus of transcripts of shame and anger episodes in autobiographical accounts, Lewis (1971) found that descriptions of anger were invariably preceded by descriptions of events where shame might reasonably be assumed to be present, but was neither acknowledged nor discussed. She also found that when shame is disavowed or 'bypassed' in this way, speech becomes more rapid and its content frequently becomes repetitive or obsessive. The narratives of people who experience paranoia may show evidence of both rapid speech and obsessive themes – for example concerning the machinations of government, the arcane powers of technology, and conspiracies of racist organisations or security forces, religious groups or aliens. The prevalence of these features in paranoia narratives suggests that disavowed shameful feelings may frequently play a significant role in the ontogenesis of paranoia, despite apparent evidence to the contrary (Fornells-Ambrojo & Garety, 2005).

So feelings act to imbue perception with meanings consonant with their character; simultaneously, they also act to bias and guide our discursive constructions in ways that avoid or circumvent negatives and orient preferentially toward positives. There is a neural dynamic between feelings, perception and discourse that on the one hand may make perception a matter of anxiety, but on the other predispose discursive constructions to orient *away* from authentic accounts of the *causes of* that anxiety. Consequently, individuals might perceive their world as a fearful and hostile place, but simultaneously be relatively handicapped in their attempts to account for their fears in terms of their own life experiences. When anxiety is also combined with shame it is likely to provide further, strong disincentives to authenticity, compounding and accentuating this neural dynamic by enmeshing it within a social and relational one by which it may be amplified, reinforced and – as will become clear – further transformed.

Gazzaniga (2000) proposes that humans have left-brain systems that spontaneously generate discursive commentaries upon our own and others' activity: although he does not link his work to Vygotsky's, his claim nevertheless seems to be that this is the neural basis of inner speech. His experimental work with split-brain patients (e.g. Gazzaniga et al., 1996) has demonstrated that discursive constructions generated by this left-hemisphere system are sometimes confabulations: demonstrably erroneous, but (consistent with a default role for feelings and a strong degree of social influence) shaped by affective influences, and oriented towards situated interactional demands. Some of Gazzaniga's studies suggest that the tendency to confabulate is also present in everyday life, a conclusion also implied by empirical work in discursive psychology (e.g. Edwards & Potter, 1992) which amply demonstrates that, whilst our discursive constructions may more-or-less loosely correspond to the 'truth', they are typically rhetorically organised, oriented towards the interactional demands of their current situation, and functional

in the sense that they endow the speaker with legitimacy, or manage dilemmas of stake and accountability.

Whilst paranoid discursive constructions may also, in a sense, be confabulations, they frequently position the speaker as relatively important or powerful, or in possession of arcane or specialist knowledge which – if true - would raise their social status. In this sense they too may be oriented towards the situated demands of social interaction, representing attempts at the relational management of feelings of anxiety and shame: consequently, narratives that are imbued with some degree of self-aggrandisement, and would have the interactional consequence (if believed) of raising their author's apparent status, are likely to be prevalent. Status-related concerns are likely to be enhanced and magnified for most who enter the realm of treatment and diagnosis, because the stigmatising associations of 'mental illness', and associated discriminatory social practices (e.g. exclusion from employment), are widely recognised (Sayce, 1998) This may be especially so for interactions with professionals, where self-presentations are not only interactionally relevant but might have additional significance because of their possible influence upon treatment or related decisions.

Whilst the specific feelings that constitute paranoia, for any given individual, will vary as a function of their particular life history and its specific trajectories of social participation, it is nevertheless possible to identify some feelings which are likely to be more prevalent than others. In accord with the literature we have suggested that feelings of shame and fear or anxiety are likely to be especially prevalent; in addition, and even though it figures less often (Combs et al., 2006) there is reason to suppose that feelings of anger are often significant. First, this is suggested by narrative accounts that presume the hostility of others and which, by relational reciprocity, suggest at least the *possibility* of hostility or anger on the part of the person generating them. Second, Lewis (1971) found that bypassed shame was frequently followed by feelings of anger, and paranoid discursive constructions display evidence of bypassed shame (rapid speech and obsessive preoccupation). Third, a small minority of people who experience paranoia do become angry and violent – most commonly toward people that they know, but sometimes towards strangers.

Feeling Traps

So paranoia is constituted by socialized feelings, which on the one hand imbue perceptions with hostility and anxiety, and on the other predispose individuals to generate discursive constructions structured by mixtures of fear, shame, anger or similar feelings. The understanding that *mixtures* of feeling are relevant is of particular significance, since it helps explain why some people *persistently* generate paranoid discursive constructions, even though their effects are stigmatizing, hinder access to employment, impair relationships, and increase social isolation. Scheff (2003) discusses the significance of mixtures of feeling, describing them as 'feeling traps' to refer to the ways in which feelings interact with each other.

When they co-occur, feelings can form self-perpetuating loops which cause them to be intensified, extended across time and generalized across social situations. For example, people who tend to blush with embarrassment may become acutely, reflexively aware that they do so. Consequently, they may become both anxious that they will blush and ashamed that they might do so: but these feelings of anxiety and shame perpetuate and intensify their feelings of embarrassment, and so make further blushing more likely. Similarly, Scheff (2003) uses biographies of Adolf Hitler to suggest that his early childhood was characterized by an ongoing

feeling trap, where anger, humiliation and abuse directed at him by his father was accompanied by adoration and love from his mother. Despite continually telling the young Adolf that she loved him, his mother failed to protect him from his father. Hitler grew up within an affective dynamic which predisposed him to feel rage and shame at the treatment meted out to him by his father, yet simultaneously to deny or ignore these feelings because they were not validated, either by his mother or by anyone else. Scheff proposes that many elements of Hitler's later comportment and behaviour (his piercing stare, obsessive character, temper tantrums, anger and continual preoccupation with pride) derive from this early socialization, which endowed him with strong propensities toward shame and anger whilst simultaneously training him to disavow those feelings. Consequently, Hitler veered between two different but equally shame-oriented ways of being in the world. At one extreme he managed a complete and thorough disavowal of his shame, evidenced by a mode of comportment consisting of rapid, high pressure speech, an aggressive domineering manner, a piercing stare and an obsessive narrative style. Alternatively, however, his demeanour was sometimes characterised by obsequiousness, excessive humility and discursive constructions of his own lowly status and lack of worth - even after he had become Chancellor.

Feeling traps, then, serve to intensify the feelings which constitute them, and to extend and generalise them beyond the relational or situational dynamics that initially produced them. In this way, they can inculcate habits of feeling, relationally acquired tendencies to feel a particular way in response to a given kind of situation or event. Their affective dynamics are acquired in a Vygotskian fashion: just as inner speech has its origins in actual conversations between people, so too the mixtures of feelings within subjectivity are relationally constituted. To the extent that we have a propensity to feel a predictable way in a given situation, this is because we have acquired this propensity on the basis of relational dynamics to which we have previously been exposed. For example, Kaffman (1981, 1983) has argued that family transactional patterns may play a critical role in the development of paranoid delusions, in particular where there is a philosophy of life characterised by inflexible rules, irrational beliefs, distrust, apprehensiveness and hate and where family members intrude on each others' actions and feelings with mutual reinforcement of paranoid ideas. Such relational dynamics may also inform developmental trajectories in teenage years, combining with pressures induced by increased consciousness of the gaze of others and feelings of trepidation associated with the expectation of becoming an autonomous agent, to contribute to the rise in diagnoses of psychosis at this age (Harrop & Trower, 2003).

Moreover, because social relations are patterned according to distinctions such as gender and ethnicity, we should expect the structuring of subjectivity to at least partially reflect these patterns. One problem of much research into paranoia is its focus on abstract, de-contextualised notions of paranoia, rather than the paranoia that might be experienced by a person of a certain gender, age, class, ethnicity and so on. When forms of difference are investigated, such research typically seeks gross differences between groups, rather than exploring subtle, nuanced variation in the meaning and signification of actual concrete experiences. It is nevertheless possible that the empirical associations between maleness and paranoia might in part be due to patterns of male socialization and their associated relational expectations of strength and the ability to protect, provide, care for and watch over others. Similarly racism, in the gross form of physical assaults, verbal abuse, prejudice and discrimination, as well as more subtle, continuous everyday minor omissions and slights, might partially account for the relationship between minority ethnic status and paranoia (Chakraborty & McKenzie, 2002). In a gendered, racially-discriminatory society, being both male and non-white is likely to be associated with relational dynamics characterized on the one hand by suspicion, mistrust, vigilance, apprehension, and anxiety, and on the other by strong imperatives to deny and disavow these feelings in order to

appear proud, competent, confident and strong. Moreover normative expectations around gender roles, racial prejudice and discrimination may mean that similar feelings, including those associated with paranoia, signify differently. For example, feelings of fear and anxiety associated with threatening city-centre environments can get configured as either 'streetwise' or 'silly' depending on gender (Edley & Wetherell, 1995).

Even though affective propensities may be acquired in this Vygotskian fashion, they are always in a continual, relational exchange with ongoing social interaction. One consequence of this is that paranoia will ebb and flow, according to changing relational and material circumstances (Garety, 1985). Another is that the mixtures of (for example) fear, shame and anger that constitute paranoia can propitiate trajectories of social participation which tend to increase social isolation, marginalisation and stigmatization. Individuals who persistently deploy paranoid discursive constructions are likely to encounter disbelief, rejection and mistrust from others, relational responses which may generate yet more feelings of fear, shame and anger – feelings which, in turn, may predispose them to produce additional paranoid accounts. In this way individuals may acquire habits of feeling that then operate pre-reflectively, structuring perceptions and activity in ways that seem simply given. Simultaneously, the responses of others may also assume habitual characteristics, perhaps of being wary about the person or vigilant about one's social contact with them. Unhelpful trajectories of social participation may ensue: feelingful modes of subjectivity characterised by mixtures of fear, shame and anger can propitiate relational choices and discursive constructions that generate yet more of these same feelings. The interpenetration, flow and exchange of relational dynamics and subjectivity can mean that perceptions repeatedly get structured by low-level mixtures of anger, shame and fear; their interpenetration can reach such a pitch that reality momentarily becomes wholly terrifying, hostile or shaming; and both of these things can happen, either alternately or in conjunction with each other.

In these ways, individuals can come to be effectively locked into socialized mixtures of intensely distressing feelings. If the relational, social and material circumstances that sustain them get prolonged, these mixtures of overt and bypassed feelings may eventually induce such a highly aroused state that anger, fear and shame come to *dominate* both perceptions and discourse. In this way, we suggest, intense, overwhelming or 'florid' states are produced - but, rather than being the outcome of faulty brains, these states are relationally generated within the embodied dialectical interchanges between perception, discourse, feeling and social relations. Moreover, once they have occurred, such states bear their own significant social and embodied meanings. Bodily, florid states may act as tipping points, momentous occasions when the apparent security and solidity of the world, usually given to us effortlessly by our embodied engagements within it, is suddenly, shockingly, revealed as a somewhat fragile achievement. In this way, what Laing (1960) called 'ontological insecurity' might be just as much an effect as a cause of distress, its experience serving to endow moments of floridity with greatly increased salience. Socially, they may be stigmatizing, devaluing and frightening because of their widely-recognised associations with pathology, illness and deviance, associations frequently emphasised by the trauma of hospitalisation and (sometimes forcible) treatment, experiences likely to themselves engender feelings of panic and loss of control (Morrison, Frame, & Larkin, 2003).

Thus, there are reciprocal, responsive relationships between embodied subjectivity and social relations, a mutually constitutive flow and interchange. Florid paranoia, as a mode of embodied subjectivity, is the emergent outcome of particular configurations of socialized feelings which mould perception, propitiate discourse and influence relationships. Like all modes of subjectivity florid paranoia is enabled by neural processes, but those processes need not

themselves be pathological. The production of feelings, their organization and influence over activity and decision making through the operation of somatic markers, the interactions between those feelings and the inner speech of the ‘interpreter’: all of these processes occur in everyday life as well as in florid paranoia, but in florid paranoia their content and their temporary patterns of relative dominance may differ. This is not to say that the brain states of people experiencing florid paranoia are identical to those of other people: they are not, since their experiences are dissimilar. But this emphasis on process might account for some of the pattern of inconsistent associations between brain structures and functions and the various diagnostic categories across which paranoia is distributed. For example, dopamine is continually available in the brain, but for highly aroused individuals it might be present at increased levels that enhance the significance of perceptions and magnify the structuring impact of mixtures of feelings. This may be why the various compounds that (amongst other effects) reduce the availability of dopamine can sometimes ameliorate florid paranoia – but may also be why their effects are neither immediate, nor universally beneficial. The ‘dopamine hypothesis’ of schizophrenia is wrong: not just because schizophrenia is an incoherent concept (Boyle, 2002) but because, like other neural processes, levels of dopamine are open to material, social and relational influences. In short, even though florid paranoia is both experienced individually and enabled neurally, its origins and maintenance are profoundly and intimately social, and to the extent that it appears as an enduring propensity or feature of an individual this is because repetition and salience have combined to render it a habitual reaction.

Paranoia, Social Structures and Material Influences

So far, this account has emphasized the relational processes by which paranoia might be produced, but all social relations are played out in material settings that, in turn, are both productive of, and produced by, societal relations of power. Consequently, by examining relational dynamics, social structures and material factors, we might begin to construct an explanation for the empirical association between paranoia and social inequality. However, in doing so we must emphasize that social inequality is not uniform, does not impact upon people uniformly, and is not responded to or dealt with uniformly. The social realm and our relations within it are complex, variegated, dynamic and mobile, so simple Humean models of causality are inadequate to its ontological complexity. For one, the great variety of shifting, dynamically interacting cultural forms, relational practices, lines of power, spatial and material organizations and temporal shifts that constitute social reality mean that there are always degrees of contingency, chance and chaos and unexpected outcomes can always emerge: social influence is *necessarily* probabilistic, not deterministic (Archer, 1995). For another, our being and becoming are always subject to the kind of radical relational uncertainty that Shotter (1993b) characterizes as “joint action”, within which the outcomes of interactions are sensitively dependent upon the dialogically-shaped co-responses of participants. Just as not all experiences of male socialization or racist social relations produce paranoia, so paranoia is neither confined to disadvantaged groups, nor ubiquitous amongst them: but we can nevertheless identify three sets of reasons why it will be more prevalent in conditions of social inequality.

A first set of reasons flows from the likelihood that the kinds of relational dynamics we have described might be more prevalent, or gain more relevance, in conditions of persistent social inequality. As Charlesworth’s (1999) sensitive ethnographic study documents, the exigencies of dealing with low status, low pay, long hours, job insecurity or unemployment produce feelings such as anxiety, misery, despair, anger and shame. Simultaneously, the material need to persist in coping with both these feelings and the circumstances that created them may encourage tendencies to disavowal or bypassing. These feelings and their consequences may impact negatively upon family life and relationships, imbuing them with a toxic character derived from

the wider social realm. Consequently, it is understandable that some people may come to favour interactional styles that are relatively hostile, distant, controlling and emotionally guarded, ways of relating with negative consequences – especially, perhaps, when they inhabit modes of parenting. Moreover, and relatedly, people may have less time and ability to bestow upon those around them the compensatory affection, love and reassurance that might counter-act and insulate against the negative feelings their social world inculcates. Additionally, there are reasons to believe that shaming and hostile discourses, and associated, devalued subject positions, can gain greater legitimacy and purchase in conditions of persistent social inequality. Angry or hostile discourses can boost status, ward off threats, and construct tough personae that make attacks and exploitation less likely. Similarly, shaming or denigratory discourses and low-status subject positions might be legitimated and reinforced by their associations with and prevalence within the processes of claiming social security benefits, working in devalued occupations, or in social relations generally where lower status is frequently presumed by others on the basis of accent, clothing, or appearance.

Second, the social and material circumstances of social inequality might themselves induce paranoia, over and above their impact upon relationships. Ross et al. (2001) argue that disadvantaged areas are typically characterized by degrees of disorder, and occupied by relatively powerless communities with low levels of overt mutual trust. People living in such areas face an increased risk of assault, theft and burglary, their material environments contain relatively high levels of graffiti, vandalism, and derelict buildings, and street drinking, drug use and visible gangs are all more common. People living in disadvantaged areas are also typically subject to greater threat and insecurity because they are more likely to lose their jobs or become homeless, social isolation is often greater, and individuals have both fewer opportunities and more restricted choices than those who are wealthier - problems which are both exacerbated by, and causal of, higher levels of ill health. In response to these material threats, people may adopt modes of comportment that decry vulnerability, shame and anxiety and present an appropriately 'hardened' exterior: 'you have to laugh, or else you'll cry' (Bleasdale, 1984).

Third, relational dynamics, social and material circumstances will interact, such that each may serve to amplify the toxic effects of the other. Increased population density, smaller dwellings, greater degrees of social and financial interdependency, and limited resources and opportunities may mean that the toxic effects of some relational dynamics are felt more keenly. For example, there is evidence that sexual and physical abuse may be causal in psychosis, a condition that frequently includes paranoia: Read, van Os, Morrison, & Ross (2005) showed that on average 69% of women and 59% of men with psychosis disclose such experiences. There is research relating male unemployment to physical abuse (Gillham et al., 1998), and showing that the incidence of physical abuse is patterned according to socioeconomic and demographic variables (Jack, 2004). Whilst there is no corresponding evidence for sexual abuse, the toxic consequences of both kinds of abuse may be magnified by social inequality, since closer proximity, more shared living space and fewer opportunities for respite or escape mean that contact with the abuser is likely to be more sustained, frequent, prolonged or intense. This does not mean that only (or all) of those subject to inequality experience paranoia, but illustrates how the contingent associations between social and material conditions and relational dynamics are synergistic, not additive (Nightingale & Cromby, 2002). Consequently, modes of florid paranoia shaped by logics that diverge far from the norm can emerge from environments and relations which appear, to outside observers, much the same as any other. But even when paranoia takes such superficially bizarre forms, this analysis suggests that it can usually be systematically related to life events, relational dynamics, and material and social conditions.

Implications

Any exposition of this kind carries the danger of reifying its subject, so we should remind ourselves again that paranoia is not a *thing* but the name we give to a mode or tendency within subjectivity. Moreover, despite the commonalities we have identified this tendency or mode is not homogenous: its interdependency with social structures, material environments and relational dynamics, themselves constantly in flux, means that its properties (narrative content, affective texture, levels of distress and preoccupation etc.) are necessarily variable. What we call paranoia will have differential qualities, both between and within individuals, according to life trajectories and the specifics of actual relationships and environments. Sometimes, as Bentall et al. (2001) propose, it might serve a predominantly defensive function, warding off threats to self-esteem by bolstering and aggrandizing the self; at other times it might be predominantly threat-laden, the direct effect of anxious, fear-laden perceptions as they feed into and are shaped by social relations (Freeman et al., 2002). In both cases it will further vary according to the relative prominence of each of the feelings (fear, anger, shame, etc.) from which it is constituted, and vary yet more according to the extent to which it is constituted from lived feelings called out *in that very moment*, versus the extent to which it is currently constituted from acquired *habits* of feeling that have become so thoroughly routine that their shadows inhabit and inflect activity and perception, even when actual, momentary feelings are not present.

This has implications for both research and intervention. With respect to research, further empirical investigation of both the relational dynamics of paranoia and their interaction with material factors and social structures is necessary. Cognitively-oriented research into paranoia might usefully incorporate analyses of social and relational factors, in so doing resolving more variance and, perhaps, refining and developing its own models. Similarly, biomedical and neuroscientific research might draw upon this notion of paranoia as a social product in order to guide investigations, choose methods, and so contribute to a meaningful social neuroscience (Cromby, 2007c).

With regard to intervention, the emphasis here on feelings suggests that many of the recommendations made by (Freeman et al., 2002) may be relevant: greater attention to the establishment of rapport, more attention to possible experiences of discrimination, and the provision of coping strategies early in therapy in order to build trust and minimize distress. Previously, much therapeutic work has focused, both implicitly and explicitly, on the veracity of beliefs, but recently an alternative focus on the 'fit' between people's beliefs and the lives they wish to lead has been suggested (Knight, 2005). Harper (2004), for example, draws on the work of the Hearing Voices movement and of Romme & Escher (1993, 2000) to argue that it is important to explore the meaning of unusual beliefs (i.e. their context and relationship to the person's biography). He suggests that therapists help the person 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 these meanings; and allows them to lead the lives they wish to. Cromby & Harper (2005) similarly advocate both a greater focus on relationships and the goal of helping clients to achieve an acceptable re-narration of their experiences, but also recommend a more explicit orientation towards paranoia's social and material dimensions. Indeed, since a frequent effect of paranoia is to increase people's isolation from others, interventions that address this may be beneficial. The development of support groups like the Paranoia Network (James, 2003) is helpful in this regard, as is help to get involved with community activities, self-help and support groups, and involvement in campaigning and other activities that engender solidarity, security and belonging. Finally, at the level of social and economic policy, it should be clear from the arguments presented in this paper that moves to ameliorate social inequality and redress its toxic effects are of enduring and fundamental significance.

References

- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th edition)*. Washington DC: APA.
- Archer, M. (1995). *Realist Social Theory: the morphogenetic approach*. Cambridge: Cambridge University Press.
- Baerveldt, C., & Voestermans, P. (2005). Culture, Emotion and the Normative Structure of Reality. *Theory and Psychology*, 15(4), 449-474.
- Bangert, M., & Altenmueller, E. (2003). Mapping perception to action in piano practice: a longitudinal DC-EEG study. *BMC Neuroscience*
Retrieved 29/11/06, from
<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=270043&tools=bot>
- Beck, A. T. (1967). *Depression: clinical, experimental and theoretical aspects*. New York: Hoeber.
- Bennett, M. R., & Hacker, P. M. S. (2003). *Philosophical Foundations of Neuroscience*. Oxford: Blackwells.
- Benson, C. (2001). *The Cultural Psychology of Self: place, morality and art in human worlds*. London: Routledge.
- Bentall, R. (2003). *Madness Explained*. London: Allen Lane / Penguin.
- Bentall, R., Corcoran, R., Howard, R., Blackwood, R., & Kinderman, P. (2001). Persecutory delusions: a review and theoretical integration. *Clinical Psychology Review*, 21, 1143-1192.
- Bentall, R., & Kaney, S. (2005). Attributional lability in depression and paranoia. *British Journal of Clinical Psychology*, 44, 475-488.
- Bentall, R., Kinderman, P., & Kaney, S. (1994). The self, attributional processes and abnormal beliefs: towards a model of persecutory delusions. *Behaviour Research and Therapy*, 32, 331-341.
- Bleasdale, A. (1984) *Boys From The Black Stuff: Studio Script* New York: Hyperion Books
- Bourdieu, P. (1977). *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.
- Boyle, M. (2002). *Schizophrenia: a scientific delusion?* (2nd ed.). London: Routledge.
- Bremner, J. D., Randall, P., Scott, T., Bronen, R., Seibyl, J., Southwick, S., et al. (1995). MRI-based measurement of hippocampal volume in patients with combat-related post-traumatic stress disorder. *American Journal of Psychiatry*, 152(7), 973-981.
- Brewin, C. (1988). *Cognitive Foundations of Clinical Psychology*. Hove and London: Lawrence Erlbaum Associates.
- Bruner, J., & Goodman, C. C. (1947). Value and Need as Organising Factors in Perception. *Journal of Abnormal and Social Psychology*, 42, 33-44.
- Chakraborty, A., & McKenzie, K. (2002). Does racial discrimination cause mental illness? *British Journal of Psychiatry*, 180, 475-477.
- Charlesworth, S. (1999). *A Phenomenology of working class experience*. Cambridge: Cambridge University Press.
- Combs, D., Michael, C., & Penn, D. (2006). Paranoia and emotion perception across the continuum. *British Journal of Clinical Psychology*, 45, 19-31.
- Cromby, J. (2007a). Feelings and Embodied Subjectivity. In V. Van-Deventer, M. Terre-Blanche, E. Fourie & P. Segalo (Eds.), *Citizen City: Between Constructing Agent and Constructed Agency* (pp.232-240) Concord, Ontario: Captus University Press
- Cromby, J. (2007b). Toward a Psychology of Feeling. *International Journal of Critical Psychology* 21, 94-118
- Cromby, J. (2007c). Integrating Social Science with Neuroscience: potentials and problems. *Biosocieties* 2,2, 149-170
- Cromby, J., & Harper, D. (2005). Paranoia and Social Inequality. *Clinical Psychology*

Forum(153), 17-21.

- Croudace, T., Bloom, R., Jones, P., & Harrison, G. (2000). Non-linear relationship between a measure of social deprivation, psychiatric admission prevalence and the incidence of psychosis. *Psychological Medicine*, 30, 177-185.
- Damasio, A. R. (1994). *Descartes Error: emotion, reason and the human brain*. London: Picador.
- Damasio, A. R. (1999). *The Feeling of What Happens: body, emotion and the making of consciousness*. London: William Heinemann.
- Damasio, A. R. (2003). *Looking for Spinoza: joy, sorrow and the feeling brain*. Orlando: Harvest.
- Davidson, R. J., Jackson, D., & Kalin, N. (2000). Emotion, plasticity, context and regulation: perspectives from affective neuroscience. *Psychological Bulletin*, 126, 890-906.
- Davis, P., & Stewart, K. (2001). Interpretations of congruent and incongruent affective communications in paranoid schizophrenia. *British Journal of Clinical Psychology*, 40, 249-259.
- Eaton, W. W., & Harrison, G. (2001). Life chances, life planning and schizophrenia: a review and interpretation of research on social deprivation. *International Journal of Mental Health*, 30, 58-81.
- Edley, N., & Wetherell, M. (1995). *Men in Perspective: practice, power and identity*. London: Prentice Hall/Harvester Wheatsheaf.
- Edwards, D., & Potter, J. (1992). *Discursive Psychology*. London: Sage Publications.
- Elias, N. (1978). *The History of Manners: the civilising process volume 1*. Oxford: Basil Blackwell.
- Fenigstein, A., & Venable, P. (1992). Paranoia and self-consciousness. *Journal of Personality and Social Psychology*, 62(1), 129-138.
- Fornells-Ambrojo, M., & Garety, P. A. (2005). Bad me paranoia in early psychosis: a relatively rare phenomenon. *British Journal of Clinical Psychology*, 44, 521-528.
- Freeman, D., Garety, P. A., Fowler, D., Kuipers, E., Bebbington, P., & Dunn, G. (2004). Why do people with delusions fail to choose more realistic explanations for their experiences? An empirical investigation. *Journal of Consulting and Clinical Psychology*, 72(4), 671-680.
- Freeman, D., Garety, P. A., Kuipers, E., Fowler, D., & Bebbington, P. (2002). A cognitive model of persecutory delusions. *British Journal of Clinical Psychology*, 41, 331-347.
- Garety, P. A. (1985). Delusions: problems in definition and measurement. *British Journal of Medical Psychology*, 58, 25-34.
- Garety, P. A., & Freeman, D. (1999). Cognitive approaches to delusions: A critical review of theories and evidence. *British Journal of Clinical Psychology*, 38, 113-154.
- Gazzaniga, M. S. (2000). *The Mind's Past*. Berkeley: University of California Press.
- Gazzaniga, M. S., Eliassen, J., Nisenson, L., Wessinger, M., Fendrich, R., & Baynes, K. (1996). Collaboration between the hemispheres of a callosotomy patient: emerging right-hemisphere speech and the left hemisphere interpreter. *Brain and Cognition*, 119, 1255-1262.
- Georgaca, E. (2004). Factualization and plausibility in 'delusional' discourse. *Philosophy, Psychiatry and Psychology*, 11, 13-23.
- Gillham, B., Tanner, G., Cheyne, B., Freeman, I., Rooney, M., & Lambie, A. (1998). Uemployment rates, single parent density, and indices of child poverty: their relationship to different categories of child abuse and neglect. *Child Abuse and Neglect*, 22(2), 79-90.
- Ginsburg, G. P., & Harrington, M. E. (1996). Bodily states and context in situated lines of action. In R. Harre & W. G. Parrott (Eds.), *The Emotions: social, cultural and biological dimensions* (pp. 229-258). London: Sage Publications.

- Griffiths, P. (1998). *What Emotions Really Are: the problem of psychological categories*. Chicago: University of Chicago Press.
- Harper, D. (1996). Deconstructing 'paranoia': Towards a discursive understanding of apparently unwarranted suspicion. *Theory and Psychology*, 6, 423-448.
- Harper, D. (2004). Delusions and discourse: Moving beyond the constraints of the rationalist paradigm. *Philosophy, Psychiatry and Psychology*, 11, 55-64.
- Harrison, G., Gunnell, D., Glazebrook, C., Page, K., & Kwiecinski, R. (2001). Association between schizophrenia and social inequality at birth: case-control study. *British Journal of Psychiatry*, 179, 346-350.
- Harrop, C., & Trower, P. (2003). *Why Does Schizophrenia Develop at Late Adolescence?: A Cognitive-developmental Approach to Psychosis*. Chichester: Wiley.
- Healy, D. (1997). *The Anti-Depressant Era*. Harvard, Mass.: Harvard University Press.
- Heise, D. R. (1988). Delusions and the construction of reality. In T. Oltmanns & B. Maher (Eds.), *Delusional Beliefs*. New York: Wiley.
- Jack, G. (2004). Child Protection at the Community Level. *Child Abuse Review*, 13, 368-383.
- James, A. (2003). Voices of Reason. Retrieved 10th December 2006, from <http://society.guardian.co.uk/societyguardian/story/0,7843,1103141,00.html>
- Jansen, A., Smeets, T., Martijn, C., & Nederkoorn, C. (2006). I See what you See: The lack of a self-serving body-image bias in eating disorders. *British Journal of Clinical Psychology*, 45, 123-135.
- Johns, L. C., Cannon, M., Singleton, N., Murray, R. M., Farrell, M., Brugha, T., et al. (2004). Prevalence and correlates of self-reported psychotic symptoms in the British population. *British Journal of Psychiatry*, 185, 298-305.
- Kaffman, M. (1981). Paranoid disorders: the interpersonal perspective. *Journal of Family Therapy*, 3, 21-30.
- Kaffman, M. (1983). Paranoid disorders: family sources of the delusional system. *Journal of Family Therapy*, 5, 107-116.
- Kaufman, G. (1991). *Shame: the power of caring*. Rochester: Schenkman Books Ltd.
- 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.
- 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, 1115-1119.
- Knight, T. (2005). You'd Better Believe It: accepting and working with the client's own reality. *Clinical Psychology Forum*, 155, 38-42.
- Laing, R. D. (1960). *The Divided Self: an existential study in sanity and madness*. Harmondsworth: Penguin.
- Le Doux, J. (2000). Emotion Circuits in the Brain. *Annual Review of Neuroscience*, 23, 155-184.
- Lemert, E. (1962). Paranoia and the dynamics of exclusion. *Sociometry*, 25, 2-20.
- Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.
- Maguire, E., Gadian, D., Johnsrude, I., Good, C., Ashburner, J., Frackowiak, R., et al. (2000). Navigation related structural change in the hippocampi of taxi drivers. *Proceedings of the National Academy of Science (USA)*, 97(8), 4398-4403.
- Maher, B. (1992). Delusions: Contemporary etiological hypotheses. *Psychiatric Annals*, 22, 260-268.
- McCabe, R., Heath, C., Burns, T., & Priebe, S. (2002). Engagement of patients with psychosis in the consultation: conversation analytic study. *British Medical Journal*, 325, 1148-1151.
- Melzer, D., Fryers, T., & Jenkins, R. (2004). *Social Inequalities and the Distribution of the*

- Common Mental Disorders*. Hove: Psychology Press.
- Merleau-Ponty, M. (1962/2002). *Phenomenology of Perception*. London: Routledge.
- Mirowsky, J., & Ross, C. E. (1983). Paranoia and the structure of powerlessness. *American Sociological Review*, 48, 228-239.
- Mitchell, S. A., & Black, M. J. (1995). *Freud and Beyond: a history of modern psychoanalytic thought*. New York: Basic Books.
- Moncrieff, J., & Crawford, M. (2001). British Psychiatry in the 20th Century: observations from a psychiatric journal. *Social Science and Medicine*, 53, 349-356.
- Morrison, A. P., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: a review and integration. *British Journal of Clinical Psychology*, 42, 331-353.
- Nightingale, D. J., & Cromby, J. (2002). Social Constructionism as Ontology: exposition and example. *Theory and Psychology*, 12(5), 701-713.
- Ohman, A., Flykt, A., & Esteves, F. (2001). Emotion drives Attention: detecting the snake in the grass. *Journal of Experimental Psychology: general*, 130(3), 466-478.
- Panksepp, J. (1998). *Affective Neuroscience*. Oxford: Oxford University Press.
- Peters, E., Joseph, S., Day, S., & Garety, P. A. (2004). Measuring delusional ideation: the 21-item Peters et al. Delusions Inventory (PDI). *Schizophrenia Bulletin*, 3-, 1005-1022.
- Poulton, R., Caspi, A., Moffit, T., Cannon, M., Murray, R., & Harrington, H. (2000). Children's self-reported psychotic symptoms and adult schizophreniform disorder: A 15 year longitudinal study. *Archives of General Psychiatry*, 57, 1053-1058.
- Raleigh, M. J., McGuire, M. T., Brammer, G. L., & Yuwiler, A. (1984). Social and environmental influences on blood serotonin concentrations in monkeys. *Archives of General Psychiatry*, 41(4), 405-410.
- Ratner, C. (2000). A cultural-psychological analysis of emotions. *Culture and Psychology*, 6, 5-39.
- Read, J., van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta-Psychiatrica-Scandinavica*, 112, 330-350.
- Rhodes, J. E., & Jakes, S. (2000). Correspondence Between Delusions and Personal Goals: a qualitative analysis. *British Journal of Medical Psychology*, 73, 211-225.
- Rogers, A., & Pilgrim, D. (2003). *Mental Health and Inequality*. Basingstoke: Palgrave-Macmillan.
- Romme, M., & Escher, S. (Eds.). (1993). *Accepting Voices*. London: Mind Publications.
- Romme, M., & Escher, S. (Eds.). (2000). *Making Sense of Voices*. London: Mind Publications.
- Rose, S. (1997). *Lifelines: life beyond the gene*. Oxford: Oxford University Press.
- Ross, C. E., Mirowsky, J., & Pribesh, S. (2001). Powerlessness and the amplification of threat: neighbourhood disadvantage, disorder and mistrust. *American Sociological Review*, 66, 568-591.
- Ruthrof, H. (1997). *Semantics and the Body*. Toronto: University of Toronto Press.
- Sayce, L. (1998). Stigma, discrimination and social exclusion: What's in a word? *Journal of Mental Health*, 7, 331-343.
- Scheff, T. (2003). Male emotions/relations and violence: a case study. *Human Relations*, 56(6), 727-749.
- Scully, P., Quinn, J. F., Morgan, M. G., Kinsella, A., O'Callaghan, E., Owens, J. M., et al. (2002). First-episode schizophrenia, bipolar disorder and other psychoses in a rural Irish catchment area: incidence and gender in the Cavan—Monaghan study at 5 years. *British Journal of Psychiatry Suppl.*, 181 (suppl 43), s3-s9.
- Sharpley, M. S., Hutchinson, G., & Murray, R. M. (2001). Understanding the excess of psychosis among the African-Caribbean population in England. Review of current hypotheses. *British Journal of Psychiatry Suppl.*, 178 (suppl. 40), 60s-68s.
- Shotter, J. (1993a). Bakhtin and Vygotsky: internalisation as a boundary phenomenon. *New*

- Ideas in Psychology*, 11, 379-390.
- Shotter, J. (1993b). *Conversational Realities: constructing life through language*. London: Sage Publications.
- Shotter, J. (1993c). *Cultural Politics of Everyday Life*. Buckingham: Open University Press.
- Shweder, R. A. (2004). Deconstructing the emotions for the sake of comparative research. In A. Manstead, N. Frijda & A. Fischer (Eds.), *Feelings and Emotions: the Amsterdam Symposium*. Cambridge: Cambridge University Press.
- Smail, D. J. (1984). *Illusion and Reality: the meaning of anxiety*. London: J.M.Dent.
- Smail, D. J. (1993). *The Origins of Unhappiness*. London: Constable.
- Social_Surveys/_Gallup_Poll_Ltd. (1995). Paranormal Behaviour. *Gallup Political Index*, 24.
- Sullivan, G., & Strongman, K. (2003). Vacillating and Mixed Emotions: A Conceptual-Discursive Perspective on Contemporary Emotion and Cognitive Appraisal Theories Through Examples of Pride. *Journal for the Theory of Social Behaviour*, 33, 203-226.
- Taylor, J., & Kinderman, P. (2002). An analogue study of attributional complexity, theory of mind deficits and paranoia. *British Journal of Clinical Psychology*, 93, 137-140.
- Thomas, P. (1997). *The Dialectics of Schizophrenia*. London: Free Association Books.
- Trower, P., & Chadwick, P. (1995). Pathways to defence of the self: a theory of two types of paranoia. *Clinical Psychology: science and practice*, 2, 263-277.
- van Os, J., Hanssen, M., Bijl, R., & Ravelli, A. (2000). Strauss (1969) revisited: A psychosis continuum in the normal population? *Social Psychiatry and Psychiatric Epidemiology*, 26, 287-292.
- Vygotsky, L. S. (1962). *Thought and Language* (E. Hanfmann & G. Vakar, Trans.). Cambridge, Mass.: M.I.T. Press.
- Weiss, J. M., Glazer, H. I., & Pohoresky, L. A. (1976). Coping behaviour and neurochemical change in rats: an alternative explanation for the original "learned helplessness" experiments. In G. Serban & A. Kling (Eds.), *Animal Models in Human Psychobiology* (pp. 141-173). New York: Plenum Press.
- Westermeyer, J. (1989). Paranoid symptoms and disorders among 100 Hmong refugees: a longitudinal study. *Acta-Psychiatrica-Scandinavica*, 80, 47-59.
- Wykes, T., & Brammer, M. (2002). Effects on the brain of a psychological treatment: cognitive remediation therapy. *British Journal of Psychiatry*, 181, 144-152.
- Zajonc, R. B. (1980). Feeling and Thinking: preferences need no inferences. *American Psychologist*, 35(2), 151-175.
- Zajonc, R. B. (1984). On the Primacy of Affect. *American Psychologist*, 39(2), 117-123.