Paranoia and social inequality

This item was submitted to Loughborough University's Institutional Repository by the/an author.


Additional Information:

- This article was published in Clinical Psychology Forum [© British Psychological Society] and is also available at: http://www.bps.org.uk.

Metadata Record: https://dspace.lboro.ac.uk/2134/2686

Publisher: © British Psychological Society

Please cite the published version.
This item was submitted to Loughborough’s Institutional Repository by the author and is made available under the following Creative Commons Licence conditions.

For the full text of this licence, please go to:
http://creativecommons.org/licenses/by-nc-nd/2.5/
Paranoia and Social Inequality

John Cromby (Loughborough University) and Dave Harper (University of East London)

Figures in square brackets in the text [p.xx] give the page numbers for the published version


John Cromby
Department of Human Sciences
Loughborough University
Loughborough, Leics LE11 3TU
Tel: 01509 223000
Email: J.Cromby@lboro.ac.uk

[p.17]
How might we make sense of the findings of epidemiological research showing the effects of social inequalities without accepting the validity of problematic diagnostic categories used by psychiatric epidemiologists (Rogers & Pilgrim, 2003)? How might we make sense of processes happening at a community and systemic level without neglecting individual experience? How should we conceptualise experiences which are embodied (i.e. felt and transmitted through our biological systems) without falling prey to dualistic or biologically reductionist thinking?

In this article, we hope to examine the links between social inequality and paranoia without falling into such traps. We use the term 'paranoia' broadly. Although single symptom research into psychosis has made great strides (e.g. Bentall, 2004) we feel there is benefit to be gained from taking the experience of paranoia as a starting point rather
than beginning with an unnecessarily narrow operational definition of, for example, the
diagnostic criteria for persecutory delusions. Paranoia, of course, is well-represented in
psychiatric diagnostic categories (e.g. paranoid schizophrenia, delusional and personality
disorders) and is in some measure a feature of many people’s everyday lives. However,
focusing on such categories assumes that the differences between them are both valid and
more important than the commonalities in the experiences they represent. Accordingly,
we begin by presenting a brief critique of psychiatric thinking about paranoia, followed
by a re-theorization that focuses on the social and material constitution of experience
through feelings. We end by outlining some implications for intervention.

Psychiatry and Paranoia
Traditionally, psychiatric theorising assumes that experiences of paranoia are simply
irrational and false, a sign of pathology whose context and content are meaningless
(Harper, 1996, 2004). However, there are grounds for rejecting each of these
assumptions.

Even though many “normal” everyday beliefs lack supporting evidence, psychiatry
typically adopts a naively realist stance towards paranoia, and diagnosis rarely involves
empirical investigation. Maher has argued that the 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’ (1992, p.261) and there appears to be
some empirical evidence of this (McCabe et al., 2002).

The view that paranoid beliefs are simply pathological and irrational ignores evidence
that people vary in the strength of conviction with which they express them (Garety,
1985), 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, are more common than psychiatry presupposes (e.g. van Os, 2000; Poulton
et al., 2000). The dimensions which seem to differentiate between those who do not
come into contact with mental health services and those who do are not their beliefs per
se but the levels of distress, conviction and preoccupation associated with them (Peters et
al., 1999). Moreover, although mainstream psychiatry traditionally treats the content of
paranoid [p.18]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).

In sum, psychiatric theorizing reductively individualises and medicalises a complex
phenomenon, obscuring its links with social conditions. To redress this problem we now
offer an alternative understanding of paranoia, focusing on how social and material
conditions produce feelings which, we suggest, are the primary cause of paranoia.

Re-theorising paranoia
Perhaps the most prominent component of human consciousness is language, the “inner
voice” that provides a running commentary on our actions. But consciousness also has a
non-verbal component which, to use Vygotsky’s memorable terminology, our inner voice
“completes”. This non-verbal component consists of feelings. Feelings include emotions
of all kinds, motivational states such as hunger or thirst, and the more subtle feelings
associated with inarticulate refusals or half-formed desires. Although feelings are
fundamental to human consciousness, in our culture their contribution to action is
frequently downplayed. When we reflect upon the reasons why we act as we do, we tend
to attribute our decisions mainly to rational-discursive factors. Whilst such factors indeed
contribute, the ever-present role of feelings as the ground upon which they are weighed
and assessed is often ignored or under-emphasised. The alternative view (supported by
most psychodynamic psychologies, cognitive psychologists like Zajonc and
neuroscientists such as Panksepp and Damasio) is that feelings have a kind of nuanced
primacy in human consciousness and are the primary determinants of motivation and
choice.

Moreover, these feelings are not just biological drives or innate instincts - they are also
socialised. There are many resources we can draw upon to understand this; limitations of
space mean just two will be briefly addressed here. First, there is extensive evidence that
emotions, the archetypal class of feelings, are thoroughly socialised. Whilst Ekman and
others hold that there are biologically hardwired basic emotions, it has nevertheless
proved difficult to determine precisely how many such emotions there are. Furthermore,
even Ekman agrees that all emotions appear within local moral orders that determine the
circumstances within which it is appropriate to experience them. Additionally, the
“display rules” that regulate how emotion can permissibly be expressed show extensive
cross-cultural variability. Further evidence for the socialisation of emotion is provided by
evidence that some cultures have emotions that others do not.

Second, Damasio’s (1994) neuroscientific work suggests that memories for events are
not only auditory or visual: they also include memories of feelings, the body-state
profiles that accompanied them. On future occasions when those events might be
relevant, their accompanying feelings can be subtly reactivated and influence decision-
making. When positive feelings previously associated with an option are reactivated, they
serve both to focus our attention upon it and make it appear more desirable. Negative
feelings do the opposite, encouraging neglect and unfavourable evaluation. Damasio calls
these reconstituted feelings “somatic markers”, and his work with brain-injured people
suggests they play a critical role in decision-making in social settings.

Socialized feelings, then, provide the primary, pre-cognitive ground upon which we
humans engage with the world, from which we assess it and make decisions. They are the
evaluative terrain upon which cognitions and perceptions are already played out, the pre-
reflective structure of meanings from within which thoughts and perceptions are always
already textured (Merleau-Ponty, 1962/2002). It is not simply that feelings provide
information about our evaluation of a situation, although they may. More importantly,
before any conscious information processing occurs, feelings shape our reactions in two
ways. First, because they focus our attention on some aspects of a situation rather than
others they shape our perceptions. Second, because they shape our evaluations of what
we perceive, they inform our interpretations and choices.

Simply put, our argument is that paranoia is principally the outcome of such feelingful
processes. It is therefore likely to afflict people whose safety, self-worth or competency
has continually been challenged, and who have received little respite or compensatory loving reassurance from others. Such people may acquire, in response to their experiences, an enduring, inchoate, habitually fearful way of being in the world, and a corresponding mode of perceiving and thinking. Feelings do not happen to the same rapid timescale as rational-discursive processes, and are not as neatly encapsulated as meanings in language. Moreover, the decisions and perceptions they regulate arise in human worlds where others will react to and interpret them. Feelings can therefore initiate and maintain trajectories of social interaction that have the unfortunate effect of stigmatising or isolating the person, further intensifying their fears and anxieties and "proving" their initial validity. Over successive interactions, fear and anxiety may thus come to structure people’s perceptions and interpretations so thoroughly that they can barely be recognised as such. It can then seem mostly obvious that the threats, slights, insults and exclusions people perceive are simple, incontrovertible features of how the world actually is.

On a case-by-case basis such outcomes may be represented as attributional errors or individual cognitive processing biases. However, in our view this cognitive approach wrongly individualises experience, unjustly translating the acquired effects of adverse socialisation into information processing flaws. In contrast, we highlight the social and material conditions of social inequality, which can encourage relatively paranoid ways of being in the world.

For example, there is evidence that disadvantaged areas typically have increased risks of assault, burglary and theft, greater prevalence of graffiti, vandalism, derelict buildings and street gangs, and are characterised by powerlessness and low levels of trust (Ross et al 2001). People there are more likely to be unemployed or homeless, to have experienced social isolation, and to have fewer opportunities, more restrictive choices and fewer resources. There are synergistic associations between these social and material conditions and adverse socialisation (see Nightingale & Cromby, 2002), and ethnographic studies clearly demonstrate their painful impact upon individuals (Charlesworth, 1999). Perhaps unsurprisingly, then, there is evidence that paranoia is associated with immigration and low socio-economic status (Kendler 1982), refugee status (Westermeyer 1980), experience of victimisation and stressful life events (Johns et al 2004). People with a diagnosis of schizophrenia often have paranoid experiences, and research shows that people with fathers occupying low socio-economic status and who were born in a deprived area are 8.1 times more likely than others to receive such a diagnosis (Harrison, Gunnell, Glazebrook, Page, & Kwiecinski, 2001); that Black and Asian people in the UK are 50% more likely to be diagnosed with schizophrenia than white people (King, Coker, Leahey, Hoare, & Johnson-Sabine, 1994); and the prevalence of schizophrenia diagnoses is higher among Black people living in majority white areas (Boydell et al 2000).

It is perhaps no surprise that if you have been excluded, marginalised, discriminated against or have faced victimisation you may start to experience the world as a fearful place, although our ways of being in the world are also shaped by wider cultural forces and more local experiences like family relationships. For example, the possibility that paranoia is more common in men (Johns et al., 2004) and young people (Ellett, Lopes &
Chadwick, 2003) merits investigation. However, space does not permit further exploration here.

**Implications for Intervention**

How might an approach like this inform interventions? At an individual and family level we need to acknowledge the socially constructed nature of judgements about beliefs and not necessarily focus on their ‘truth’ or otherwise. Instead we should pay attention to the content of a person's paranoid belief and be sensitive to its context in the light of their personal history. We should aim at enabling people to get a better 'fit' between their beliefs and the lives they wish to lead. Research on those who hear voices highlights the benefits for people of developing explanations which allow them to make sense of their experiences (and do not unduly distress them); which provide contact with a community which shares these meanings (e.g. spiritualist churches, hearing voices group etc); which involve certain helpful practices (e.g. meditation, political action etc.), and which allow them to continue living their lives in a relatively undisrupted manner (Romme & Escher, 2000). From our perspective, it is highly relevant that feelings of safety, security, warmth and even love, are likely to be integral to such groups and practices.

However, work at an individual and family level is not enough. We should support initiatives to combat the social isolation produced by the fragmentation of community life and the excessive individualism of Western culture. One approach is to help set up support groups for people experiencing paranoia, similar to those fostered by the Hearing Voices Network (James, 2003; Knight, 2004). There is also a need to build trust within neighbourhoods in order to combat victimization, and to support broader initiatives aimed at addressing social inequalities and fighting victimisation and racism (activities engendering feelings of solidarity and belonging and a sense of identity which may themselves be therapeutic). Finally, these approaches are unsustainable without national policies which consistently challenge discrimination and injustice. In a sense, we could view the received psychiatric view of paranoia as a form of ‘false consciousness’ which obscures the real causes of distress, locating it in faulty brain mechanisms, rather than out there in a sometimes hostile world. In contrast, we could draw on ideas from liberation social psychology (Burton, 2004) to facilitate a process Ignacio Martin-Baro called *conscientización* by which people can educate and liberate themselves from oppressive social conditions.

**References**


