Self Representation in two types of paranoia

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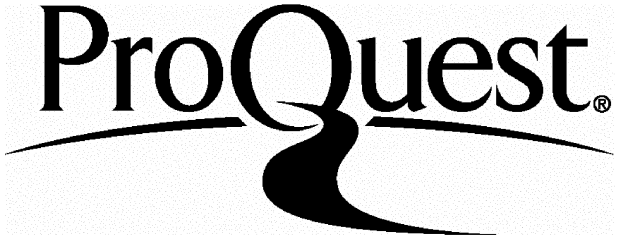

ABSTRACT

This study compared subjects who had 'poor me' (PM) and 'bad me' (BM) paranoia. The first part aimed to determine if Ss with PM and BM paranoia had distinctly different parenting experiences, purported to be associated with anaclitic (dependent) and introjective (self-critical) kinds of depression respectively. It was therefore an attempt to indirectly test proposal that PM is a defense against anaclitic depression and BM a defense against introjective depression (Trower & Chadwick, 1985). The second part explored how the personal constructs for the two kinds of paranoia were different. It focussed on the possibility that the structure of personal construct systems for the PM and BM groups, would reflect perceptual defensive styles of repression and sensitisation respectively.

Following screening for formal thought disorder and adequate literacy levels, 19 Ss suffering from paranoid delusions. Two measures of type of paranoia were used, the first a categorical measure (PM and BM) and the second a dimensional measure of paranoid attributional style (Plausible Scenarios Questionnaire). Ss completed a self-report measure of parenting experiences (Parental Bonding Instrument PBI) and a measure of personal constructs Structural measures, which had previously been found to be associated with repression and sensitisation, were derived from the grids.

No difference was found between PM and BM groups (using either classification) on the PBI for levels of care or overprotection, except that PM (attributions) reported significantly higher maternal overprotection, although this no longer held after controlling for thought disorder. The structural measures derived from participants' rep. grids showed none of the expected differences. The results do not support the proposal that PM and BM paranoia are defenses against anaclitic and introjective depression, but the parental antecedents for these kinds of depression may still be poorly understood.

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Tables and Diagrams

CHAPTER ONE

INTRODUCTION

This thesis will examine a proposal by Chadwick & Trower (1995) that there are two kinds of paranoia, '*poor me*' and '*bad me*'. Trower & Chadwick's model suggests that these two different kinds of paranoia are defenses against two different kinds of depression, *anaclitic* and *introjective* depression respectively (Blatt & Zuroff, 1992). The two kinds of depression, are thought to be engendered by differences in the nature of early attachments with primary care-givers. This study will explore these proposed links between early attachment experiences and type of paranoia. Secondly potential links between the defenses used in either kind of paranoia, and those used by repressors and sensitisers will be explored. The assumption that similarities existed between the defensive styles of repressors and 'poor me' s on the one hand and sensitisers and 'bad me' s on other, will be examined by comparing repertory grids structures with known grid structures of these two kinds of perceptual defense. In addition, it will examine other potential differences between the construct systems of the two groups implicated by Trower & Chadwick's model.

This chapter will begin by reviewing other theoretical explanations for paranoia or persecutory delusions, emphasising psychological explanations over cognitive neuropsychological (e.g. Frith, 1992) or biological explanations (e.g. Weinberger, 1987). This will be followed by a detailed summary of Trower & Chadwick's explication of the two kinds of paranoia, and review evidence in support of there being distinctive types of depression that have distinctive causes in terms of early attachments. It will then explore Trower & Chadwick's work, by considering how the self might be understood and represented for these two groups of individuals, with particular reference to the theoretical framework first put forward by George Kelly (1955), that of Personal Construct Theory

(PCT). There will then follow an overview of the PCT literature on perceptual defense. Finally, the research questions will be outlined.

Defining Delusions

In the past, delusions were defined as qualitatively different from normal thinking processes. For example, DSM-III-R (American Psychiatric Association, 1987) defined delusions as false beliefs based upon incorrect inferences about external reality, firmly sustained in spite of others' beliefs and in the face of directly contradictory evidence. In addition, such a belief was considered to be at odds with prevailing cultural norms.

This viewpoint has been criticised on a number of grounds (e.g. Chadwick, Birchwood & Trower, 1996). Firstly, the idea that delusions have to be false appears not to ring true with clinical experience e.g. a person may believe something with delusional intensity that indeed turns out to be true. Furthermore, it is often impossible to decide whether or not a belief is true, making diagnosis based upon this criteria impossible (Heisse, 1988 cited in Chadwick et. al., 1996).

The question of whether delusions can be thought of as occurring due to incorrect inferences being made about reality does have some support. Bentall, Kinderman & Kaney (1994); Garety (1991) found abnormalities in attributional style and probabilistic reasoning respectively.

The idea that delusions are held with greater rigidity than ordinary beliefs, though less controversial than the above criteria, is nevertheless problematic because certain categories of so-called normal or non-delusional beliefs have similar properties. For example, articles of religious faith are held with unerring conviction. Furthermore, variation in the degree of conviction in delusions has been found both within groups (Harrow, Rattenbury & Stoll,

1988) and within individuals over time (Garety & Hemsley, 1987). That delusions are not amenable to reason or are unmodifiable has been refuted on empirical grounds by studies which show that with skilled cognitive-behavioural interventions, levels of conviction have been altered (e.g. Alford, 1986; Alford & Beck, 1994; and Chadwick & Lowe, 1994). However, just because it is possible to change delusional believes in this way, does not mean that these beliefs are not more difficult to modify than non-delusional beliefs.

The notion that delusional beliefs are at odds with prevailing cultural norms has been criticised on a number of grounds. Firstly, in order to decide whether a given belief is at odds with a norm assumes that such norms are easily identifiable. Furthermore, a singular, prevailing cultural norm is difficult to ascertain within increasingly multi-cultural societies (Kendler, Glazer & Morgenstern, 1983). Conceptually, the idea of normal versus bizarre ideas becomes increasingly tenuous when one considers the range of what is considered normal both across different societies and throughout history (Harper, 1992).

Finally, Brockington (1991) argues that a belief can be true and yet at the same time qualify as a delusion. The reason being that it is the kinds of evidence used to support the belief, rather than the belief itself that denotes a delusional quality. Consequently, if a neutral third party were to hear the story of why John (see chapter 3) believed that someone was trying to kill him, it would not be an evaluation of whether such a story *could* be true, but whether the kinds of evidence brought forward to support the belief were sufficiently convincing. This allows culturally normative beliefs to qualify as delusions.

Strauss (1969) preferred to think of delusions as lying on a continuum with normal beliefs, varying only in terms of the degree of conviction and level of pre-occupation with which they are held. Recently this perspective has gained greater acceptance within the research community. For example the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-R, APA, 1994) incorporates the idea that delusions 'usually involve a

misinterpretation', and recognises that 'the distinction between a delusion and a strongly held belief is sometimes difficult to make and depends on the degree of conviction'. It also notes that determining bizarreness 'may be difficult to judge'. Furthermore it does not state that these beliefs cannot be changed.

For the purposes of this thesis, delusions were defined within the context of a person's involvement with mental health services, and based upon clinicians' evaluations of symptomatology. This may have meant that different clinicians may have used different definitions, but the researcher attempted to cross-check clinical data obtained from notes and clinicians with interview material gathered directly by the researcher where possible.
In summary, a number of factors were taken into consideration in order to determine whether someone's beliefs were delusional. These were: the judgement of the clinician, the length of time the belief had been held, how strongly it was held, the person's reaction to hypothetical contradictory evidence, the credibility of the belief, and how general or specific it was. For example, the more specific a person's belief, the easier it is to assess its credibility. So "X is trying to poison me by looking at my drinks" is probably delusional whereas "my neighbours are trying to get me evicted by making a mess around my flat," could well be true. If someone said that wherever they moved to, their neighbours tried to get them evicted by making a mess (a more general belief), one would be less likely to consider it to be true. Furthermore, the participants' beliefs had to imply that the person or agent doing the persecuting *intended* some *harm*, which is perhaps in contrast to earlier studies, and may further confound any findings if this discrimination was not made (Garety & Freeman, 1999).

Historical overview of delusions

Despite the prevalence of paranoia in our societies, featuring as it does in a number of psychiatric disorders, and as a familiar feature of everyday thought processes, there are few

empirically grounded theoretical explanations for its cause and maintenance. Three reviews of theoretical explanations for delusions stand out, the first by Arthur (1964), the second by Winters & Neale (1983) and the third by Butler & Braff (1991). These papers will be summarised in the following section.

Arthur (1964) reported that Kraeplin focussed his efforts on describing delusions as accurately as he could rather than trying to explain their origin, though he did have a theoretical stance on delusions, seeing them as reactions to great disappointments in life. In contrast the same author told of how Bleuler thought that delusions were caused by disruptions in affectivity and association, and made a distinction between two kinds of delusions. Basic delusions, were viewed as developing from major affective themes in a person's life e.g. persecutory delusions. Elaborative delusions were errors in thinking caused by the person's need to make apparently contradictory information compatible with the delusional belief.

Arthur (1964) mentions the Heidelberg school approach, which was held by Jaspers, Gruhle, Schneider and Mayer-Gross. This essentially viewed delusions as 'incomprehensible beliefs'. It distinguished between primary and secondary delusions. Primary delusions were beliefs that could not be related to the person's experiences or personality. Although such delusions may have been thought of as essentially having a defect rather than a motivational cause, no perceptual disturbance was necessarily implied as occurring in the person with a primary delusion. On the other hand, a secondary delusion was seen as being related to a person's mental state or to environmental events.

In their review of theoretical explanations for delusions, Winters & Neale (1983) proposed dividing these into 'motivational' and 'defect' theories. 'Motivational' theories assume that the individual develops the delusion either to explain unusual experiences or to reduce uncomfortable psychic states (e.g. unfulfilled need). On the other hand, 'defect' theories

assume that delusions arise from some fundamental cognitive-attentional deficit. Hingley (1992) pointed out that the 'motivational' and 'defect' models may well overlap for an individual if the person is motivated to compensate for an original defect, such as a cognitive deficit. The distinction between 'motivational' and 'defect' models of delusions serves as a useful heuristic. There is also considerable overlap between this dichotomy and that proposed by Schneider (1958) classifying delusions as primary if they were caused by some fundamental thought disorder or secondary if they were attempts to explain unusual perceptions.

Janet (1932) thought that most delusions were linked to particular affects: feelings of emptiness, separateness or aloneness, were thought to lead to persecutory delusions, and feelings of reference were thought to be caused by an inability to participate in social life. Highlighting the role of emotions in the formation of delusions seems to anticipate the modern understanding of delusions as psychologically meaningful experiences.

The idea that delusions were a result of poor intellect (Gruhle, 1932; cited in Arthur, 1964) has not been supported in empirical studies (e.g. Davidson, 1963; Chapman & Chapman, 1973). A similar notion was that delusional thinking was a product of more regressive thinking resulting in faulty logical reasoning (e.g. Storch, 1923; Reiss, 1940, cited in Arthur, 1964), however there is only equivocal support for this position.

Winters & Neale (1983) reported that Bleuler saw delusions occurring because of disturbances in thinking and affect. He thought that the persons capacity to think in terms of associations based on experience was unable to assert itself in the face of stronger associative links based on emotional experience alone which recruited logical thinking to support the 'hunches' that sprung from this dominance of emotions. This is a specific formulation of formal thought disorder as causing delusional thinking. However, not all

people with delusions suffer from formal thought disorder, and furthermore, many people suffering from delusions appear to exhibit an absence of affect e.g. in schizophrenia.

The idea that people with delusions have faulty reasoning, was investigated by Bentall, Kinderman and Kaney (1994) who did find that such individuals showed an exaggeration of the self-serving bias, tending to make excessive external attributions for negative events and internal ones for positive events. Garety (1991) also found differences from normals on tasks of probabilistic reasoning. However, these findings are countered by other findings that people with delusions are more rational than normals (Chadwick, Birchwood & Trower, 1996). There is also the contradictory finding that this group of people have excessive 'bottom-up' thinking styles (excessively influenced by stimuli) on the one hand, and excessive 'top-down' thinking styles (excessively influenced by expectations and prior beliefs) on the other.

In contrast to the idea that delusions are a by-product of dysfunctional thought processes, other theorists have taken the position that delusions are a result of reasonable attempts to understand unusual perceptual experiences. This position goes back to Freud (1915) who thought that his patient Schreber had an initial delusion as a result of an interpretation of some biological change that he was undergoing. The main proponent of this position in recent times was Maher (1974) who thought that biological disturbances caused perceptual anomalies, which were in turn interpreted using intact reasoning. The finding that a greater proportion of people with hearing deficits than those with average hearing, experience delusions would tend to support Maher's view (Cooper, Kendell, Gurland, Sharpe, Copeland and Simon, 1974). One problem with this theory is the question of why people would tend to make delusional interpretations rather than more naturalistic ones. Again this criticism assumes that it is easy to make a distinction between normal and delusional thought processes, and this appears to be one of the central problems.

Kretschmer (1927) can be considered one of the first people to attempt to combine the two different explanations for delusional thinking. He saw delusion formation as an interaction between an organic illness (defect) and aspects of the personality (motivation). As a fore-runner to recent theories which see delusions as attempts to defend against low self-esteem, he too thought that the aggression in someone with paranoia was an attempt to cope with low self-esteem. However, in contrast to cognitive theories, he thought that an organic illness was a necessary pre-condition for the expression of these ideas.

Theoretical explanations for delusions

In the following section, the major psychological explanatory theories for delusions falling broadly into the category of 'motivational explanations' will be reviewed.

Existential theories

Kronfeld (1930, cited in Arthur, 1964) viewed delusions as 'the result of the failure of the "objectifying act" because of the strength of the "intentional act." "Objectifying act" refers to the capacity to be aware of one's own actions and intentions, and "intentional act" referred to the capacity to wish, desire and imagine some particular action. Arthur also drew a parallel between this confusion about the origins of one's own acts and intentions and the psychoanalytic concept of projection. Frith's (1992) thesis that people suffer from delusions as a consequence of a deficit in meta-cognition, resulting in an inability to distinguish between intentional acts and reflex actions, is remarkably similar to Kronfield's ideas.

Other authors within the existential tradition tend to take a more holistic approach to understanding the nature of delusions, preferring to see the whole person, rather than just their symptom. Such an approach was exemplified by Biswanger (1958) who saw delusions as pathological world designs. For him, world designs were the organisation of all the

conscious and unconscious attitudes and perceptions of the self and the external world. Similarly, Gudeman (1966) saw delusions as attempts to organise the world in such a way as to maintain an illusion of control in an uncontrollable situation; they were seen as creative attempts to organise the world in order to protect the self.

Forgus and DeWolfe (1974) examined the idea that a person's delusions would be reflected in the content of their constructions of the world around them and their relationship to it (Ey, 1955), by comparing the content of delusional themes and reality constructs. Their findings broadly supported Ey's ideas.

Psychoanalytic theories

Most psychoanalytic theories of delusions employ the concept of projection. According to Freudian theory, in the case of persecutory delusions, homosexual love is repressed and converted by a reaction-formation into homosexual hate, so "I love him" becomes "I hate him." Finally, the paranoid process is complete when the person projects these feelings of hate onto the object, transforming "I hate him," into "he hates me." Swanson, Bonert and Smith (1974) simplified this, suggesting that persecutory delusions were just projected hostility. Indeed Overall, Gorham and Shawyer's (1961) finding that hostility and paranoia co-vary would tend to support this, although more parsimonious explanations are available as to why these two variables might co-vary, mainly that someone who is paranoid is more likely to be hostile anyway. A study by Silverman (1976, cited in Winters and Neale) which demonstrated that his sample of people with schizophrenia became more aggressive when exposed to subliminal stimuli with aggressive content, is problematic because it was unclear whether his sample were indeed paranoid before exposure to the stimuli. Furthermore, attempts to replicate his findings have failed (Heilbrun, 1980).

The evidence to support the Freudian position is far from convincing. Although it has been shown that people who are paranoid are more consciously pre-occupied with homosexuality (e.g. Moore and Selzer, 1963), this would not be the expected finding because such thoughts would be repressed and unavailable to conscious awareness. Projective tests to determine the content of someone's unconscious thoughts could be used, although their efficacy has been questioned on the grounds of unreliability (Winters and Neale, 1983).

Other psychodynamic thinkers have proposed that paranoid thinking is a projection of self-blame (Sullivan, 1965). Sullivan thought that in addition to self-blame, the person must have some kind of pre-disposition towards suspiciousness which undermined corrective feedback by incorporating it into a suspicious world view.

Learning theories

Learning theorists, Dollard and Miller (1950), Cameron (1951) and Mednick (1958) thought that delusion formation was based on avoiding some highly unpleasant emotion. Mednick more specifically, suggested that delusions occurred in persons who had behaved in such a way as to produce a shame or guilt reaction in themselves. The delusional explanation is simply the one that explains the behaviour without producing the shame, guilt or other unpleasant emotion.

Ullmann and Krasner (1969) thought that delusional speech was developed and maintained by the same learning principles that guide normal speech development. They saw delusional speech as an attempt to gain some positive reinforcement in the absence of this for appropriate social behaviour. Although studies have shown that delusional speech can be extinguished in the same way that any other behaviour can (e.g. Davis, Wallace, Liberman and Finch, 1976) this neither shows that the delusional ideas are no longer present nor sheds any particular light on the causes of delusions.

Cameron (1951) postulated that delusional attributions are made when stimuli associated with a stimulus that originally provoked an anxiety response, also provoke this same response because of a broadening of the generalisation gradient. From this he predicted that the stimulus generalisation gradient would become increasingly broader eventually leading to perceptual disorganisation. Cameron also invokes the disposition to make premature closures when faced with ambiguities in their perceptions, and it is these closures that form the basis of delusional thinking. Cameron's theory does not explain why people with other anxiety disorders do not also develop paranoia in the same way as those with delusions. It is certainly true that anxious people have fleeting paranoid ideas, however, these rarely have the qualities of a delusion i.e. held with unerring conviction over a prolonged period of time (in the order of weeks, months and sometimes years).

The concept of projection is used in Cameron's re-working of his theoretical position on delusion formation. Winters and Neale (1983) report that he thought that there were stages of developing delusions. Cameron postulates that during the first phase, the individual is frustrated by his lack of social skills and withdraws into a fantasy world. This in turn leads to regression to an earlier phase of that person's personality development, when more primitive fantasies and conflicts were prevalent, and these begin to re-emerge. Cameron thought that such an individual would not be able to repress these thoughts and feelings so instead they would be denied and projected onto others, and manifested as blame and anger. In the next stage, the individual attempts to make contact with the world again but finds it a changed and hostile place, which further reinforces a vigilant and suspicious disposition. In the penultimate phase, projection increases making contact with a world which once offered a sense of perspective impossible. The final phase results in the paranoid individual having to make preliminary hypotheses (delusions) that pertain to fears about the intentions of others. Although this is a nicely elaborated theory, Winters and Neale note that the data

comparing pre-morbid social adjustment between people with paranoia and people without paranoia, shows that this is better in people with paranoia (Zigler and Levine, 1973).

Mednick develops Cameron's model by suggesting that delusions are further bolstered by a process of negative reinforcement when stimuli that are on the periphery of the generalisation gradient do not invoke anxiety, but instead offer relief and confirmation of the delusional belief. Mednick's theory replaces the need for Cameron's trait of premature closure with a trait for having a lower anxiety threshold and greater anxious reactivity than normals. However, Cameron's theory might better explain why some and not all, anxious individuals become paranoid.

Colby's (1975) shame-humiliation theory argued that paranoia develops from a person's disposition towards viewing the self as inadequate or defective. Paranoia is the outcome of the person's attempts to deflect the negative affect associated with these negative self-views onto others. Winters and Neale (1983) notes that no one has demonstrated that paranoid delusions are a defense against humiliation, and that depressives who do have low self-esteem rarely become paranoid. However, many of the subsequent cognitive theories such as that put forward by Bentall, Kinderman and Kaney (1994) strongly support the idea that delusions are an attempt to defend against negative self-evaluation.

Cognitive theories

One of the first cognitive theories of paranoia was proposed by Heilbrun (1973, 1975, cited in Butler and Braff, 1991). This theory, which also incorporated elements of Social Learning Theory, suggested that children who are exposed to very negative communication patterns from their parents adapt in one of two ways. They either adopt social approach strategies and perceptual vigilance, the so-called *open adaptive* style or they adopt strategies of social withdrawal and perceptual defense, the so-called *closed adaptive* style. Both are seen as

attempts to protect the self from negative evaluation. Heilbrun thought that these two different approaches made individuals vulnerable to two different kinds of delusional thinking because of the way in which the two groups dealt with negative evaluative information. He thought that *open style* thinkers processed this kind of information by a "broad search of stimuli, selective perception of negative cues, premature attribution of meaning, denial, and erroneous projection of negative evaluative information to others," which caused information over-load and disorganised thinking. In an attempt to avoid the aversive consequences of their disorganised thinking, such a person was thought to adopt a false rationale as an organising principle. This is reinforcing for the individual because it reduces the levels of anxiety associated with disorganised thinking, and forms the basis of a delusional premise.

Heilbrun (1975) thought that *closed style* thinkers avoided evaluative information by avoiding the social environment, in order to protect their fragile self-esteem. Paranoia develops as a consequence of recognising that others are aware of this desire to hide and so attempts at contact are seen as deliberate attempts to invade a self-imposed privacy. It is from this awareness that the individual develops the ideas that they are being persecuted or pursued, and Heilbrun utilised the concept of selective abstraction to explain why such an idea carries greater and greater conviction for it. In other words, a person then selectively attends to information in the environment that supports the persecutory idea whilst distorting ambiguous information to further support it. Butler & Braff (1991) suggest that this is an example of a defect theory, presumably the cognitive style of the child being the defect in question, however, such 'cognitive styles' develop for motivational reasons: to make sense of negative communication patterns in parents.

Various analogue studies of perceptual and affective processes have successfully managed to differentiate people who had reactive schizophrenia from those who had process schizophrenia (e.g. Heilbrun, 1972). This is particularly impressive given that Heilbrun

(1975) made a link between open-style adapters and reactive schizophrenia, and closed style adapters and process schizophrenia. In support of Heilbrun's position, Zigler and Levine (1973) showed that delusions from reactives reflected better organisation, greater articulation and hierarchical structure, whilst process patients showed more global, disorganised and diffuse delusions.

Following on from Heilbrun, Zigler and Glick (1988) argued that both paranoid schizophrenia and mania are disguised forms of depression that have the psychological function of defending the person against extreme forms of negative self-evaluation, similar to the defensive functioning found in mania. Their proposition was that the two separate disorders were two different phenotypes or expressions of a single genotype – i.e. had a single genetic cause. If this was the case, they contended that there should be similar developmental patterns found between mania and paranoid schizophrenia. The evidence that they cited in support of this thesis was: similar age at onset; similar levels of pre-morbid functioning (social and cognitive); similar treatment responsiveness and outcome; and similarities in perceptual and cognitive functioning (paranoid schizophrenics are: less distractible, have faster reaction times; are less over-inclusive in their thinking and show higher developmental levels than non-paranoid schizophrenics).

Fear, Sharp and Healy (1996) argued that it was not a simple case of all paranoid delusions being a defense against depression. This is not necessarily inconsistent with Zigler and Glick's (1988) position. They stated that different genotypes can lead to the same phenotypic expression, and that different phenotypes can be expressions of the same genotype. Fear et. al. (1996) made a particular case for distinguishing between delusional disorder (DD) and paranoid schizophrenia (PS) on the basis of different age of onset, delusional systems being generally much more circumscribed in DD, and more intact personalities in DD, whereas PS generally involves other psychopathologies, including auditory and occasionally visual hallucinations.

A good theory of personality ought to be able to throw some light on the nature of delusional thought. Cognitive theories of personality, which conceptualise a person in terms of schemata may be able to throw some light on the nature of the phenomena. More specifically, cognitive theory would suggest that delusions are a particular way of representing schemata about the self, others or the world. It is worth considering the nature of schemata at this point in order to think about how one would make meaningful predictions on the basis of cognitive theory.

Markus and Sentis (1982) note that schemata provide categories for organising the vast amounts of information that a person has to deal with. Schemata describe both the *process* of organising this information, as well as particular *structures* that possess informational content. It is thought that they organise information by making decisions of best fit between existing meaning structures and new information, furthermore, they are elicited by particular stimuli in what would appear to be a passive way. These processes are both considered to be automatic and effortless, making no demands upon an individual's attentional resources (Power and Brewin, 1990). Experimental evidence in support of these organising principles has been demonstrated by Bargh (1982) using a dichotic listening task. He found that individuals' reaction times for recognition of schematic words was much faster than for non-schematic descriptors.

Other methods devised to infer a person's schemata are the incidental recall task, and the Stroop colour word-naming task as used by Bentall and Kaney (1996).

Following on from Zigler and Glick (1988), Kaney and Bentall (1989) and Bentall, Kaney and Dewey (1991) looked at the attributional style of people with paranoid delusions. They found that the paranoid group tended to make many more global, stable, person attributions for negative events and more internal attributions for positive events. This is an exaggerated form of the so-called self-serving bias found in normals and a reversal of the attributional

style of people with depression, who generally make more internal attributions for negative events (i.e. blame themselves rather than blame others).

Bentall, Kaney and Kinderman (1994) and Bentall et al. (1996) proposed that persecutory delusions were attempts to defend the self against low self-esteem, which is so closely associated with depression. They used an incidental recall task, but were careful to get participants to make a decision about whether each word could be applied to them before testing recall. In this way, they were able to look at the incidental recall for schematic words as opposed to non-schematic words. Their findings supported this proposition partially. In the deluded (both depressed and non-depressed), the recall of words did not reflect their initial endorsement patterns, whereas for the normal and depressive controls, their incidental recall did reflect their initial endorsement patterns. If a word was schematic for the participant it should have been recalled more easily, however, both deluded groups remembered a lower proportion of positive than negative words that they had previously endorsed as self-descriptive. One problem for their thesis was that if delusions were a defense against depression, then why were so many paranoid people depressed? Secondly, if deluded people were engaged in attempts to avoid or defend against negative self-evaluation, then why did they so freely endorse themselves with these negative traits? The answer to these questions may be that people with persecutory delusions are only partially successful in defending against depressed feelings and negative self-evaluations.

In Support of Two Different Kinds of Paranoia – 'poor me' & 'bad me'

In a further development of the cognitive model of paranoia as a defense against low self-esteem, Chadwick & Trower (1997) compared people who experienced paranoia, with depressed people and normal controls on the Evaluative Belief Scale (EBS; Chadwick, Trower and Dagnan,1996), a measure which had previously been found to be a reliable and

valid measure of negative evaluative beliefs, and the Beck Depression Inventory (BDI, Beck, Steer and Gabin, 1988). The EBS looked at the extent to which individuals endorsed negative person evaluations in three categories, *self-self* (or self evaluation), *self-other* (an evaluation of another person) and *other-self* (a perception of being negatively evaluated by another person). They found that the paranoid group endorsed significantly more self-other evaluations as previous research on attributional style with similar populations had shown (Bentall et al., 1991). They also found that levels of depression in the paranoid group were lower than the depressed group, but levels of depression in this group were significantly higher than the normal controls. What was particularly enlightening was the discovery of two different patterns of response on the EBS for the paranoid group. One group endorsed significantly greater numbers of negative *self-self* beliefs, resembling the depressed group, whereas the other group endorsed significantly greater numbers of negative *self-other* beliefs, as had been the case in Bentall et. al.'s research on attributional style in paranoid disorder. Although they found that the paranoid groups were more depressed than the normal controls, they were significantly less depressed than the clinically depressed group (Chadwick and Trower, 1997). Additionally, Chadwick and Birchwood (1994) found in their study of secondary delusions (to auditory hallucinations) that their participants could be broken into two groups. Both attributed the voices to a malevolent source but one group thought they were being justifiably punished whereas the other group thought that they were being undeservedly persecuted. The same authors, when carrying out cognitive-behavioural interventions for delusional beliefs, had also observed a sub-group of people whose paranoid beliefs seemed to be intrinsically linked to a low self-esteem. They proposed that these two separate groups were both using paranoia as a defense against depression, but that the depression had different themes.

On the basis of these findings, Chadwick and Trower (1997) in keeping with a cognitive formulation of these two different kinds of presentation, thought that the group which endorsed greater numbers of negative *self-self* evaluations resembled the people called '*bad*

me's in rational emotive behaviour therapy (REBT), and the other group '*poor me*'s. People who were '*bad me*' s thought of themselves as defective and blameworthy and deserving of punishment, whereas people who were '*poor me*' s saw themselves as undeservedly persecuted through no fault of their own. They argued, that '*poor me* 's would feel angry or self-pitying whereas the '*bad me*' s would feel anxious afraid, or shameful.

Chadwick and Trower (1997) claimed to be supporting Zigler and Glick's (1988) original proposition that paranoid schizophrenia and mania were disguised forms of depression. However, Trower & Chadwick approached the problem at a symptom level, whereas Zigler and Glick approached it at syndrome level; the two sets of authors were also formulating within different theoretical frameworks, a psychological one and a biological one respectively. The crucial difference then between Trower & Chadwick's model of '*bad me*' and '*poor me*' paranoia and Zigler and Glick's model, is that the former conceptualises paranoia as an attempt to defend the self from two distinctive kinds of threat.

In elaborating this position, they drew upon the literature on self-presentation (Goffman, 1959; Jones, 1990 and Schlenker, 1980). They postulated that the self-construction or identity is something, which is constantly being formulated and reformulated by the individual via the following process. Firstly, individuals present behaviours for others to observe and evaluate, secondly, the other provides feedback about this presentation and finally this feedback is evaluated in terms of an evaluation of the self or an evaluation of the other. They describe different kinds of self: the *subjective self*, which is the originator of the self-presentation behaviours for others to evaluate, and the *objective self*, which is the self as constituted by the *subjective self*'s appraisal of feedback from the other.

Chadwick & Trower (1995) describe two major problems that can occur with the formation of the self in a person's early years. Firstly, if there is an absence of mirroring and/or feedback from significant others, then the *objective self* is either never sufficiently formed or

is formed in a very weakened version resulting in an *insecure self*. Secondly, if feedback is non-contingent on the self-presentation behaviours of the *subjective self*, in other words, the carer is overwhelming and controlling, and constitutes the objective self for the infant, regardless of the infants behaviour, then this results in an *alienated self*.

Putting this model of self-formation into the context of depression, these authors suggested that these two problematic selves, the *insecure* and *alienated*, are at the root of two different kinds of depression. The first has a theme of dependency, the need for acceptance, and the second is concerned with the need for self-definition and autonomy. There follows a review of evidence for the two kinds of depression, which should illuminate the potential differences in childhood experiences for the two types of paranoia.

Evidence for two kinds of depression

Various authors have made a distinction between two kinds of depression, one based on problems of attachment and interpersonal relationships and the other based on problems of self-definition, individuation and achievement. Bowlby (1977, 1980, 1988) talked about anxiously attached and compulsively self-reliant individuals, and argued that both were attempts to defend against perceived interpersonal loss in childhood. Arieti and Bemporad (1978, 1980) from an interpersonal tradition distinguished between *dominant other* and *dominant goal* types of depression. In the former the person craves passive satisfaction from a dominant other whereas in the latter, the person craves assurance of their self-worth and to be free from guilt. Beck (1983) proposed a distinction between socially dependent or *sociotropic* and *autonomous* types of depression. The former orientated towards maintaining attachments whilst the latter orientated towards maintaining independence and achievements. Blatt and colleagues (Blatt, 1974; Blatt et al., 1976; Blatt et al., 1982; Blatt and Shichman, 1983; Blatt, Wein, Chevron, and Quinlan, 1979) proposed a distinction between *anaclitic* (dependent) and *introjective* (self-critical) depression. *Anaclitic* depression is characterised

by feelings of loneliness, helplessness and weakness in which the individual has a fear of being abandoned and left uncared for. As a consequence, sufferers have great difficulty expressing anger for fear of losing the other. *Introjective* depression is characterised by feelings of low self-worth, self-criticism, feelings of inferiority, failure and guilt, sufferers can be critical of others because of their intense competitiveness.

Blatt and Zuroff (1992) reviewed the evidence for two kinds of depression and its corollary, of two personality styles. They described these traits in non-depressed individuals: dependent individuals were described as having a strong need to be loved, cared for and protected, fearing abandonment and loss of love. They engaged in behaviours, which minimised conflict and thus did not express anger easily (Blatt, 1974). Self-critical individuals were described as desiring self-control, self-worth, and identity (Blatt and Shichman, 1983). They desired approval, respect and admiration, and feared disapproval and loss of control and autonomy.

Blatt and Zuroff (1992) reviewed four different kinds of studies. The first kind looked at the interpersonal styles of people found to have personality styles consistent with attachment pre-occupation (dependent), as opposed to those people who had personality styles consistent with achievement orientation and self-definition (self-critical). The second kind of study looked at the interaction of proximal life events with the two personality styles. The third kind of study looked at subliminal mood induction protocols and the fourth kind of study looked at associations between distal life events and the two personality styles. Each of these will be reviewed in turn.

Evidence for two kinds of depression based upon assessment measures of depression

These two different kinds of depression have been measured using various self-report scales. Blatt, D'Afflitti and Quinlan, (1978) developed the Depressive Experiences Questionnaire

(DEQ) which has been found to have three underlying orthogonal factors: *dependency*, *self-criticism* and *efficacy*. Measures of these three factors have been found to be stable over time, and have high internal consistency. The self-criticism factor related highly with traditional measures of depression such as the BDI (Beck et. al., 1961) and the Zung (1965) depression scales. Although one criticism that Blatt and Zuroff (1992) made was that too many of the items appeared to correlate with measures of state depression and therefore did not necessarily tap into personality styles or traits. Beck, Epstein, Harrison, and Emery (1983) also developed the Sociotropy-Autonomy Scales (SAS), which attempted to measure Beck's concepts of sociotropy and autonomy. Only the Sociotropy Scale correlated with the BDI. Also, the sociotropy scale significantly correlated with Blatt's DEQ dependency and self-criticism scales and the autonomy scale significantly correlated with the efficacy factor in the DEQ, but not with the former two scales in the DEQ.

The Dysfunctional Attitude Scale (DAS, Beck and Weissman, 1978) was also developed to measure underlying dysfunctional assumptions, which might pre-dispose an individual to become depressed. A factor analytic study was carried out which yielded two major, stable factors, the first of these was "approval by others and performance evaluation" whilst the second was concerned with a "need for approval and perfectionism," (Cane, Olinger, Gotlib & Kuiper, 1986). It has been criticised because its subscales correlated too highly with each other.

Blatt and Zuroff (1992) noted that these psychometric problems appeared to be answered by the development of the Personal Style Inventory (PSI, Robins and Luten, 1991). This took into account issues of construct definition, internal consistency and convergent and divergent validity. They reported that initial results were promising, in that the PSI sociotropy and autonomy scales predicted symptom patterns in depression (Robbins & Luten, 1991).

In another study (Zuroff and de Lorimier, 1989) subjects were divided into the two groups: those with high dependency needs and those with high self-definition needs based upon their responses on the DEQ. They found that high DEQ dependency scores predicted those college women who would describe their ideal boyfriend as requiring high need for intimacy rather than masculinity or achievement. Further research of this kind has elaborated consistent personality differences between the two groups, as distinguished on the DEQ measures of dependency and self-definition.

Evidence for two types of depression based upon proximal precipitating events causing dysphoria

The second kind of study looked at the stressful events associated with triggering the two kinds of depression. Both laboratory analogue studies (Zuroff and Mongrain, 1987) and cross-sectional, retrospective studies (Segal, Shaw, Vella, and Katz, 1992) with normals and depressed participants respectively, supported a specificity of causes of the two kinds of depression but with some ambiguity of findings, namely a lack of specificity for self-critical individuals. Interpersonal difficulties were associated with dependent kinds of depression in nine out of twelve studies examined by Blatt and Zuroff (1992). However, they noted that there was less specificity for self-critical individuals whom they speculated were vulnerable to both interpersonal difficulties and experiences of failure.

Evidence for two types of depression based upon laboratory studies of subliminal triggers for negative self-evaluation

Laboratory studies used subliminal messages to examine their effect upon participants defined as dependent or self-critical on the basis of responses to the DEQ. These provided mixed results in terms of being differentially vulnerable to messages with themes of abandonment or self-criticism. Dauber (1980, 1984), Brennan (1984) and Koufopoulos

(1986), all found that a message "leaving Mom is wrong" produced negative affect in self-critical women, thought to be associated with a dependent personality style. However, Schmidt (1981; Schmidt, Fallot & Dickson, 1985) found that dependent individuals were more sensitive to subliminal statements that encapsulated a fear of object loss: "I have lost Mommy." Fonseca (1987) found that the statement "I am all alone", produced the most negative affective responses in DEQ dependent women. Studies have also supported the position taken by Blatt et al. (1992) in that self critical women were also found to be vulnerable to subliminal messages about the self being 'bad', which links into themes of separation and individuation (Fernandez, 1986). Blatt et al. (1992) claim to have demonstrated that "dependent and self-critical subjects were differentially responsive to subliminal and supraliminal themes of abandonment, loss, and rejection or themes of failure and self-criticism." On the basis of the above findings, this appears far from conclusive, in fact they do concede that there were more "inconsistent" findings for the self-critical group.

This picture was complicated by Smith, O'Keefe and Jenkins (1988). They found that dependent males and self-critical females had a *heightened* vulnerability to depression triggered by interpersonal loss and achievement respectively, as opposed to self-critical males and dependent females, which seemed to be mediated by problematic relationships with the parent of the opposite sex.

This raised the question of whether the presence or absence of gender match between parent and child was an important variable in determining depression in later life. Blatt et al. (1992) reported a number of studies that gave conflicting results as to whether the same-sex parent or the opposite-sex parent was more important in determining depression in later life. They noticed that problems with the same sex parent were critical in the child's early years (five years old in the studies quoted) and that problems with the opposite sex parent were critical in middle childhood (eight years in the studies quoted). They concluded that the same-sex parent relationship with the child seemed to be more important in determining

problems in later life, suggesting that the first five years of a person's life is the most critical stage.

Evidence for two types of depression based upon distal causal events and depression in adulthood

The fourth kind of study examined by Blatt and Zuroff in support of their thesis was the relationship between distal causal events and depression, and particular events in early childhood. Generally speaking, studies linking reported parenting style as measured by something like the Parental Bonding Instrument (PBI, Parking, Tupling and Brown, 1979) with vulnerability to depression have found a link between this vulnerability and an emotionally cold, absent, unavailable and controlling parenting style (e.g. Zemore and Rinholm, 1989). It would seem that the lack of care was more frequently implicated in determining vulnerability to depression, and that intrusive control was also a factor but less frequently (Blatt and Zuroff, 1992).

McCranie and Bass (1984) in studying female nursing students found that dependent (DEQ) women perceived their mothers to be dominant, controlling and insisting on conformity. In contrast, self-critical women reported both parents to be inconsistent in displaying affection and maintaining control by emphasising achievement. Although the second part of this finding supports Blatt and Zuroff's conceptualisation of critical events in determining self-critical kinds of depression, the first part of the finding does not accord with their supposition that dependent individuals would have received absent or neglectful parenting, although Blatt et al. (1992) interpret inconsistency in displaying affection as a form of lack of care and therefore as supporting their position. Brewin, Firth-Cozens, Furnham & McManus (1992) reported a significant relationship in women between degree of self-criticism and reports of a maternal lack of care and increased overprotection (affectionless controlling) as determined by responses on the PBI. Additionally, Koestner, Zuroff &

Powers (1991) found that levels of self-criticism in twelve year old boys and girls was predicted by mother's reports of their own parenting as being rejecting and restrictive.

Blatt and Homann (1992) noted the lack of correspondence between dependent depression and reported lack of love in the parenting relationship. They accounted for this by arguing that as dependent individuals want to maintain their attachments at any cost, their personality develops in such a way as to inhibit expressions of anger for fear of loosening attachments with others; the assumption being that reporting a lack of care would be an angry response. They also suggested that because these issues were played out in a relatively early part of life, that pertinent parenting behaviours were difficult to remember. They speculated that McCranie and Bass's (1984) measure of inconsistency was not measuring inconsistency of parental care but inconsistency of approval, which pertains to a later stage in childhood.

Blatt et al. (1979) found that dependent adults described their parents at the lowest developmental level, followed by self-critical adults and finally non-depressed adults. This may make verbal representations of such experiences for dependent individuals more challenging for these individuals and distort responses on measures like the PBI.

Blatt et al. (1992) concluded that further research was required to identify the proximal and distal antecedents of dependency and self-criticism. This is particularly relevant given the finding that DEQ had a third factor in addition to absent/neglectful and critical/ controlling styles of parent called was self-efficacy, which involved items indicating a sense of confidence about one's potential ability to cope with challenges. None of the studies examining distal events and vulnerability to depression appeared to take this third and potentially protective factor into account.

Relevance to Trower & Chadwick's model

Trower & Chadwick (1995) linked this conceptualisation of self-formation with the theoretical distinctions made by Blatt and Zuroff (1992) between *anaclitic* (dependent) and *introjective* (self-critical) styles of depression. In the model of self-formation described, the dependent kind of depressed person was particularly pre-occupied with negative evaluation from the other, and was pre-disposed to perceiving negative *other-self* feedback when feedback was ambiguous. They were also pre-occupied with maintaining their existing attachment relationships. Trower & Chadwick (1995) suggested that such a person would either attempt to ignore this feedback and only endorse positive feedback from others, which is reminiscent of the strategy adopted by the manic patient, or alternatively, they would attribute the perceived negative feedback from the other as due to some characteristic of that person, in other words make an external attribution for this negative feedback, what has been referred to as the self-serving bias observed in normal and paranoid subjects (Bentall et al., 1991). This they suggested, is the pattern of defense associated with '*poor me*' paranoia, where the integrity of the *subjective self* remains intact but there remains the impoverished if not non-existent *objective self.*

Trower & Chadwick(1995) argued that someone who has a self-critical kind of depression, is unable to defend against the perceived negative feedback from the other person because they accept it as axiomatically true, in other words the truth is that they *are* a bad person. Their only defence against this is to hide away from perceived evaluation. This it was argued, is the strategy of the '*bad me*' paranoid. They argued that the person with '*bad me*' paranoia, who had been on the receiving end of a critical and controlling parent, had not had the chance to develop a *subjective self*, which is the originator of the self-presentation behaviours for others to evaluate.

What Trower & Chadwick (1995) failed to explain was why such a defensive strategy in the person with '*bad me*' paranoia, should involve the formation of paranoid delusions. The simplest defense for such an individual would be withdrawal from a social life, or leading a highly restricted social life. Perhaps these delusions serve to mask the real reason for the withdrawal of the self from the social world and thus maintain some delicate sense of self that is not weak or inferior.

The other problem for the mapping of these two kinds of depression onto a typology of paranoia, is the finding that for the *introjective* (self-critical) kind of depression, individuals seemed to show concern to maintain attachments plus a self-critical orientation. (e.g. Zuroff & Mongrain, 1987). In practice this is likely to mean that individuals with '*bad me*' paranoia are likely to have concerns about negative interpersonal evaluation of themselves and concerns about maintaining attachments too, as is supposed to be the case for someone with '*poor me*' paranoia.

Despite suggesting that PBI scores for the two types of paranoia might reveal neglectful, inconsistent or absent parenting for both groups, and critical and controlling for the people with a 'bad me' type of paranoia, Trower & Chadwick (1995) failed to speculate on the potential effects of a third factor. This factor, identified by both the DEQ (Blatt et al., 1992) and the PBI (Murphy, Brewin & Silka, 1997) is that of *encouragement of behavioural freedom.* This dimension encapsulates attitudes and behaviours that may have promoted the strength and independence of the child as opposed to overprotecting him or her. This may act as a moderating variable to reduce the impact of the other two.

Conceptualisation of defenses in the two types of paranoia

Trower et al's (1995) formulation of the two types of paranoia and the defensive function of each type has not yet been examined within a Personal Construct Theory (PCT) framework. In fact no studies have been published that look at the relationship between repertory grid structures and the symptom of delusions. The remainder of this chapter will review how defenses are conceptualised within PCT, and will attempt to draw comparisons between these conceptualisations of defenses and the way defenses are thought to operate in 'poor me' and 'bad me' paranoia.

A Personal Construct Theory Perspective

Theoretical overview

Personal construct theory states that people are motivated to make sense of their world in order to discriminate between and to anticipate events (Kelly, 1955). Kelly made an analogy between people and scientists, they make hypotheses, test them and then revise their hypotheses based on the outcome of the tests. However, people are not always good scientists and may not revise their hypotheses (construct systems), they may even abandon experimentation altogether. Kelly (1955) regarded a psychological disorder as 'any personal construction which is used repeatedly in spite of consistent *invalidation*'.

Before considering what happens to people who have a psychological disorder it is worth reviewing Kelly's view of normal psychological processes. He thought that people have a system of bi-polar constructs that are hierarchically linked such that an *element* (Kelly's technical term for the object being construed) construed in one way has implications for other constructs that may be applied to it.

Constructs can be thought of as *preemptive*, which indicates exclusive application to the anticipation of an event, *constellatory*, which means that other constructs are connoted or implied by it, and *propositional*, which neither excludes nor implies other constructs. Therefore, a person who has a tightly organised construct system may have a system consisting of a greater number of constellatory constructs, and a person who has a fragmented or *loose* construct system may have a greater proportion of preemptive or propositional constructs.

For example, consider a person who has the construct 'good listener' in their system (they discriminate between those who are good listeners and those who are not), and that they think it is likely that good listeners are always 'caring' (this is the anticipatory or predictive component of construct systems). If this person came across a good listener who was not caring, the individual experiences an *invalidation* of a part or whole of their construct system, depending upon how *superordinate* the construct 'good listener' is. *Superordinacy* can be thought of as how many constructs have to change if a given construct has to be changed. The more *superordinate* a construct is, the more resistant to change it is. Those constructs linked to a person's identity Kelly termed 'core' constructs which are invariably *superordinate* constructs and particularly resistant to change. Kelly considered that individuals who found themselves acting in a way that was inconsistent with their core role experienced guilt.

The process of invalidation is always accompanied by or preceded by *anxiety*. Kelly conceived anxiety as the inability to construe events within a particular field. The individual in our example then has a number of options. They could either, *loosen* the linkage between the two constructs so that being a good listener no longer has any relation to whether or not they would be a caring person, or ignore the new information and continue to maintain the absolute link between the two constructs. These two strategies are extreme forms of strategies that Kelly called *dilation* and *constriction* respectively. A third response would be

to reverse the relationship between the two constructs in the face of contradictory experience, e.g. all bad listeners are caring. This is referred to by Kelly as 'slot rattling', and can be seen as yet another maladaptive attempt to extort validation from one's environment.

Dilation is an opening up of the perceptual field and the conceptual field to allow new connections or constructions to be made in the system, and can increase the predictability of the construct system. E.g. Some bad listeners are also caring because they are distractible (a new construct has been introduced which mediates the relationship between being a good listener and being caring). In this instance a greater differentiation occurs within the construct system. As such, *dilation* is a normal process that allows for greater differentiation to be made between elements in a person's perceptual field. An extreme form of *dilation* occurs when the link is broken altogether between the two constructs, in other words, the business of prediction has been abandoned for this focus of convenience (the range of elements to which the construct has been applied to by the person).

The opposite process to *dilation*, known as *constriction,* involves the closing down of the perceptual field, such that the relationship between being a good listener and being caring remains unchanged.

How are psychological problems conceptualised within a Personal Construct Framework?

Various aspects of construct systems have been found to be associated with particular psychological disorders. For example, one characteristic of people with depression is their use of *constriction* (Catina, Tschuschke and Winter, 1989). *Constriction* is assumed to be operating when a person operates with a limited number of undifferentiated constructs, therefore the constructs would be found to be highly correlated when looking at a repertory grid for such a person. Another manifestation of *constriction* within a person's construct

system is that the depressed person finds many of their constructs inapplicable to other people.

The above finding has been supported by a study by Silverman (1977) who found that people with depression had significantly *tighter* construct systems for affective constructs only, as compared with a normal control group, although the control group for this study did have higher socio-economic status and higher average intelligence. Also, Sheehan (1981) found that depressives had *tighter* construing of peoples' constructions of them than a normal control group. Other studies have failed to differentiate depressives from comparison groups, including normal controls (e.g. Neimeyer, Klein, Gurman & Greist, 1983b).

A construct system in which constructs are highly correlated, such that the invalidation of any construct carries implications for the predictive utility of the entire system, particularly the core constructs, is known as a *tight* construct system, and this is characteristic of the construct systems of people with depression. The crucial difference between people who have depression and those who don't seems to be in the nature of the core constructs. People without significant psychological disorders have been found to have relatively *permeable* core constructs, meaning that they are able to tolerate the inclusion of new elements within their range of convenience. A good analogy is that of a good theory in science which has a universal applicability, such as Newton's Universal Theory of Gravitation, which purported to be applicable to all objects in the universe. This theory was permeable because its predictions could accommodate new data. This is a paraphrasing of Kelly's (1955, p.7) 'Modulation Corollary'.

The most widely researched disorder involving *loose* construct systems is that of schizophrenia, as demonstrated by a classic series of studies (Bannister, D., 1962). In these studies he found that people with schizophrenia had low correlations between constructs, suggestive of weak relationships between them, such that a change in one would not

necessarily bring about a change in many other constructs. The method used in these studies was later refined into a measure of schizophrenic thought disorder (Bannister and Fransella, 1967), the measure used in this study to exclude those individuals with formal thought disorder. *Loose* construct systems are thought to be attempts to avoid *invalidation* (Kelly, 1955) and thought disorder is considered to be an extreme form of this strategy. Inconsistent and poorly correlated constructs have been found to be more characteristic of psychological constructs rather than physical ones in people with schizophrenia, even when applied to the same elements, but are more apparent when people rather than objects are construed (Bannister and Salmon, 1966; McPherson and Buckley, 1970; McPherson et al., 1975; Heather, 1976 – cited in Winter, 1992, p.80). All of these studies were working with diagnosis as an independent variable, rather than symptoms. However a study by Foulds (1965) did find a distinction between 'integrated psychosis', which included people diagnosed with schizophrenia who had stable and coherent subsystems of constructs and who were likely to exhibit delusions of persecution, and those people with schizophrenia who showed much less stable construing, as indicated by low consistency scores on the Fransella and Bannister Grid Test of Schizophrenic Thought Disorder. A study by Dingemans et. al. (1983) also distinguished between people with paranoid and reactive schizophrenia who were found to have higher Consistency and Intensity (a measure of how highly constructs are correlated with each other) scores than those with non-paranoid and so-called *process* schizophrenia.

A Personal Construct Theory Understanding of Paranoia

This methodology has never before been used to look at paranoia at a symptom level. Its strength is that it captures aspects of both structure and content of mental representations. Other measures of cognitive contents, such as the Spontaneous Trait Generation (STG) task (e.g. Markus, 1977) tend to impose a frame of reference, whereas the grid procedure does not when elements and constructs are elicited from the subject. Whilst PCT is not a cognitive theory as such, it has some shared qualities – one of the major differences between the two approaches, is that PCT does not assume a universality in terms of specific cognitive contents predicting specific psychological disorders (Winter, 1992; p.109).

'Poor me' and 'Bad me' paranoia considered in terms of Personal Construct Theory

This section will attempt to make links between the two different kinds of defenses that are thought by Trower & Chadwick (1995) to be used by the two groups of paranoids and the personal construct theory literature on psychological defenses. Here it is worth re-stating the different defenses outlined by Trower & Chadwick for the two groups.

The strategy of the '*poor me*' paranoid is to maintain attachment relationships whilst at the same time maintain a positive construction of themselves (*subjective self*) often in spite of perceived negative *other-self* feedback. Their strategy is to make external attributions for negative *other-self* feedback, maintaining a positive *subjective self*, at the cost of an impoverished or non-existent *objective self* (the self as reflected in others feedback about one's own behaviour). Essentially this is purported to be a defense against a depression encapsulated by feelings of loneliness and isolation.

The strategy of the '*bad me*' paranoid is to attempt to minimise negative affect by withdrawing from the challenge which social life presents. The persecutory delusion serves

as an excuse to make this withdrawal. Social life is toxic for '*bad me*' paranoids, because they are pre-disposed to perceive ambiguous *other-self* feedback in negative terms and feel over-whelmed by it, because they have an *alienated self.* In summary, the '*bad me*' delusions are thought by Trower & Chadwick to be a defense against feelings of worthlessness and self-blame.

A Personal Construct Theory understanding of defenses

Various mechanisms are available to the person who is confronted with anxiety or *invalidation.* Some are adaptive in that they enable the person to adjust their construct system to make more predictable those events within that particular range of convenience. Some may be characterised as quasi-defensive, in that they ward off the threat of invalidation but at the cost of making the construct system less predictive.

In an optimally functioning person, the *creativity cycle* (involving anticipation of an event, investment, encounter, confirmation or disconfirmation and finally a constructive phase, which might involve developing new constructs or changing the nature of existing constructs) is characterised by the oscillation from *loose* to *tight* construal. This cycle is repeated ad infinitum. The person who gets stuck in the *loose* phase is over-using the strategy of *dilation.* The person who gets stuck in the *tight* phase of the cycle is over-using the strategy of *constriction.* Either *constriction* or *dilation* may be resorted to if the emotion experienced as a consequence of invalidation is beyond the individual's coping resources (Catina, 1987). People who over-use the strategy of constriction might expect to have tightly organised construct systems and those who over-use the strategy of dilation might tend to have loosely organised construct systems.

One area of study that has attempted to systematically measure psychological defensive styles is known as perceptual defense. It is this literature that personal construct theorists

have drawn on in trying to find grid measures that correlate with these other measures of psychological defensiveness. The following section will briefly review this literature.

Perceptual defense, is the term used to describe the way in which individuals differ in the way they automatically respond to threatening stimuli. Individuals are thought to fall along a continuum, one end of this being represented by individuals who tend to avoid, repress or deny threatening stimuli, with at the other end, individuals who tend to approach, intellectualise or obsess (Byrne, 1961). People who tend to avoid threatening stimuli are referred to as *repressors.* Such people are reported by Byrne (1961) to have been found to remember successes better than failures in a scrambled-sentence task, to forget an anxiety arousing 'Blacky' picture and to respond to a sentence-completion test with blocking, avoidance, denial and clichés.

Those who tend to approach threatening stimuli, are known as *sensitisers.* These individuals are reported by Byrne to have a tendency for recalling failures and material associated with painful shock, to have a shorter latency for aggressive words in a word-association test and to respond to a sentence-completion task with admissions of inadequacy, failure, rationalisation, intellectualisation and humour. Byrne considered the possibility that this trait may be unstable in a person over time, but rejected it. Byrne, Barry & Nelson (1963) found that sensitisers were more likely to report an incongruence between self and ideal-self, specifically that they were more likely to admit to negative self-evaluations. Conversely, repressors tend to describe themselves more positively on Leary's Interpersonal Checklist (Attrocchi et. al., 1960: cited in Byrne, 1961) and in a Q-sort task (Block & Thomas, 1955; Chodorkoff, 1954: cited in Byrne, 1961). Repressors share qualities with individuals identified as having a dismissive attachment style and sensitisers with individuals employing a pre-occupied attachment style (Dozier & Lee, 1995). This is an additional reason why the person with 'poor me' paranoia who appear to use a dismissive attachment style, may share grid qualities with people who use denial and repression. However, Dozier et al. (1995)

found that dismissive attachment style was associated with looser thinking, although this was not measured using a grid, and therefore may be referring to a different phenomenon.

Relationship between grid measures and measures of perceptual defense

Wilkins, Epting & van de Riet (1972) found an association between sensitisers and *cognitive complexity* on the one hand, and repressors and *cognitive simplicity* on the other. *Cognitive complexity* is 'the capacity to construe social behaviour in a multi-dimensional way' (Bieri et. al., 1966), and has been measured in a number of ways. One such way involves assigning a score of 1 to every *element* with the same score for a given *construct*, the total score reflecting *cognitive simplicity*. Sensitisers have also been found to differentiate more between self and others, particularly identifying themselves on negative dimensions (Carr & Post, 1974).

Catina, Gitzinger & Hoeckh (1992) looked at peoples' tendencies to use the defenses of denial, rationalisation and turning against the object, with various grid measures. They found that denial was associated with *tight* construing, construing of the real self and social self as similar, and construing of their symptoms as carrying few positive implications. Rationalisation on the other hand was associated with high dilemma scores, as indicated positive construal of their psychiatric symptoms and in addition, a greater ability to discriminate people on the basis of emotional constructs. Although they did not measure repression or sensitisation per se, they measured aspects of personality closely associated with the two, denial with repression and rationalisation with sensitisation.

Implications for the personal constructs of 'poor me' and 'bad me' paranoids

It would seem that the person with 'bad me' paranoia has both repressive and sensitising behaviours, only one of which is about coping. The coping aspects of their personality

strongly involve the paranoid belief in giving the person a reason to avoid threatening people. However, like those with depression, people with 'bad me' paranoia are more vulnerable to negative self-evaluation, and may therefore may also have a disposition towards approaching threatening situations in order to attain mastery, more in keeping with that of a sensitiser. People with a 'bad me' paranoia also endorse more negative self-self evaluations than the 'poor me' group. This accorded with findings by Catina et al. (1992) that people who used rationalisation as a defense were more likely to construe positively the negative symptoms that they suffered from, rationalisation being one of the defenses identified as used by sensitisers (Byrne, 1961).

People with '*poor me*' paranoia appear to use a repressive style of defense, namely, that they tend to have an enhanced version of what is known as the self-serving bias in attribution theory terms i.e. the tendency to make external attributions for negative events and internal attributions for positive ones. Repressors have been described in literature (Byrne, 1961) as individuals who tend to avoid endorsing negative self descriptors, and prefer to deny and avoid. Certainly the exaggerated self-serving bias appears to be an extreme manifestation of such a strategy.

If this comparison between '*bad me*' paranoia and sensitisers on the one hand and '*poor me*' paranoia and repressors on the other is merited, then one might expect to find similar structural differences in the two groups of paranoids, as that found in the two styles of perceptual defense. This difference would probably be a matter of degree, given that the distinction between repressors and sensitisers has been found to be a continuum, and that people with 'bad me' paranoia also use repressive styles of coping. The other possibility is that people with 'poor me' paranoia are projecting rather than repressing, and therefore such a comparison may be less warranted, although given that projection is a kind of avoidance, one might still expect to see less cognitively complex grids.

Following Catina et al.'s (1992) finding that people who use denial tend to have a small distance between the way in which the self and the social self (their construal of how others construe them) are construed, and tighter construct systems, then the same pattern might be expected to occur for people with a 'poor me' style of paranoia. In addition, the '*bad me*' group would have more cognitively complex grids than the '*poor me*' group, given the relationship between sensitisation and cognitive complexity (Wilkins et al, 1972). Finally, given that sensitisers are less inhibited about accessing and using emotional terms (Catina et al, 1992), the '*bad me*' group may use a higher proportion of emotional constructs than the '*poor me*' group.

There is the possibility that both kinds of paranoia are different manifestations of a repressive defensive style, in that people with '*bad me*' paranoia tend to avoid others – the behavioural form of *constriction* (Winter, 1989) – this being the case, then little difference may be found between the two groups.

Other aspects of construct systems in 'poor me' and 'bad me' paranoia

What other qualities might the grids of the two groups have? Given the nature of how the two groups score on the Depressive Experiences Questionnaire (DEQ), i.e. people with a 'poor me' style of paranoia tend to give responses consistent with high self-esteem and those with a 'bad me' style give responses consistent with low self-esteem, one might expect the '*poor me*' group to show a smaller discrepancy between the self and ideal-self scores, equivalent to higher self-esteem. This would appear potentially to be a good way to discriminate between the two groups using grid measures.

As noted earlier in the paper, the person with '*poor me*' paranoia is engaged in an attempt to maintain a positive view of themselves despite evidence to the contrary. In order for the self-construct system to be maintained in the face of potential invalidation, such a subsystem

would need to be relatively impermeable and possibly more meaningful for the individual than for the people with '*bad me*' paranoia, for whom the self is perhaps relatively at the mercy of *other-self* feedback, and is therefore more engaged in *dilatory* strategies. More meaningful construct subsystems have greater differentiation than less meaningful ones, therefore, one might expect to find that the '*poor me*' group have cognitively more complex views of themselves than the '*bad me*' group or that relatively speaking, the difference between constructions of self and other in terms of cognitive complexity are greater for the '*poor me*' group than the '*bad me*' group. Other theorists have suggested that more extreme ratings denote more meaningful constructs.

People with 'bad me' paranoia avoid contact with the *other* in an attempt to defend the *self* from becoming over-whelmed and possessed by the *other*. A corollary of avoidance in PCT terms would be *constriction*, which is defined as not attending to events that are incompatible with the construct system. Although *constriction* is defined more as a psychological strategy, the outcome for someone who limits their experiences either through avoidance or *constriction*, would be *tight* construal of others (Winter, 1992). In practice this would mean that other people in general would be poorly differentiated in grid ratings. According to Trower & Chadwick, the 'bad me' paranoid's *subjective self*, such as it is, is always in danger of being taken over by the *objective self*, of being constituted by the other. In order for this to be possible, constructs applicable to the self would have to be *permeable* enough to allow for this. The greater permeability of a construct, the more elements it can be applied to (Winter, 1992). One would also expect loosely organised constructs applied to the self.

Rational for the present study

Reasons for choosing a symptom-based approach

This study is follows a recent trend in research on delusions (Hingley, 1992), that of studying the phenomena at a symptom level, rather than a syndrome level. The reasons for doing this are twofold. Firstly, it enables comparison between findings of this study and other recent studies, and secondly, the utility of studying syndromes has been criticised on the grounds that a diagnostic syndrome such as schizophrenia, has failed to meet the demands of scientific validity. Namely, such a diagnosis does not predict prognosis, or best treatment and neither does it predict a specific symptom pattern, but rather a range of potential symptom patterns (Bentall, 1990 and Boyle, 1990). In addition to the above, studying individual symptoms allows a greater consideration of the psychological meanings of them, without necessarily ruling out the possibility that a syndrome approach is useful one.

However, delusions within schizophrenia may be qualitatively and quantitatively different from delusions in other psychotic disorders (Harrow and Quinlan, 1977). This would suggest that other variables are being brought to bear on the kind of delusion that a person experiences, and therefore to ignore this issue and only look at symptoms as an independent variable, may introduce unnecessary confounds. However, given the difficulty in recruiting people with delusions at all, this study was not able to exclude people with a particular diagnosis or only take people who had delusional disorders, as was the case for the Chadwick et. al. study (1996).

In this study, the use of the PSQ was discontinued when it was found to have poor discriminant validity. However the data that had already been collected was used to explore the possibility that propensity to use one type of paranoid attribution or another was

associated with either sub-scale of the PBI. This was considered an important addition to the study, given the lack of specificity of distal causes for the two types of depression and the lack of specificity in terms of themes of pre-occupation for people identified as having dependent or self-critical personalities (Blatt et al., 1992).

The model

This study tested the proposition that people identified as experiencing persecutory delusions with themes of 'poor me' and 'bad me' would be discriminated by a measure of remembered parenting, the PBI which assessed levels of neglect and overprotection. It was assumed that categorisation into 'poor me' and 'bad me' groups could be reliably achieved. Furthermore, this study assumed that levels of depression would not moderate responses on this measure of remembered parenting, based upon findings by Parker (1981) that levels of depression did not affect responses on the PBI. Therefore, no measure of depression was taken. Strictly speaking, this study does *not* test the proposition that these two different types of paranoia are a defense against depression with different inter or intra-personal themes. If it were, then measurement of levels of depression using something like the DEQ would be warranted, given that paranoia is supposed to operate as a defense against it.

Secondly, this study explored the way in which these two groups of paranoia differentially construed themselves and their interpersonal worlds.

Research Questions

This thesis will focus on attachment patterns and the nature of self-representation for the two groups highlighted in the above review.

1.) This first question assumed that a dependent kind of depression had been associated with absent, neglectful or inconsistent parenting, and tests the proposal that 'poor me' paranoia is a disguised form of dependent depression by examining responses on the PBI. A similar pattern of responses on the PBI between people with PM paranoia and people with a dependent kind of depression would be expected if the experimental hypothesis were to be confirmed, i.e. low care scores on the PBI. Similarly, assuming that 'bad me' paranoia is a disguised form of self-critical depression, one would again expect the reported parenting experiences of the former group to resemble the latter group, i.e. low care – high overprotection on the PBI. The presumed link between a dependent kind of depression and neglectful or absent parenting remains controversial, given the mixed findings reported in the Blatt & Zuroff (1992) paper, and remains untested. Given the above set of assumptions, one would expect to find both PM and BM groups to report low levels of care, but that in addition, the BM group to report at least one overprotective parent.

2.) The predictions made in this question remain more speculative than the prediction made in the first question, and the spirit of carrying out a grid study was more explorative than hypothetic-deductive. Essentially, this second question was concerned with how the structure and content of the thinking for these two groups, as assessed by a repertory grid might be different. Based upon the 'poor me' group utilising defenses such as denial and repression, one might expect that compared to people with 'bad me' paranoia, their grids may tend:

(i) to have a small distance between the way in which the self and the social self (their construal of how others construe them) are construed, and low differentiation between constructs for the social self. Another possibility is that the opposite effects may be seen, i.e. that countering self-ideal discrepancies by attributing negative other-self feedback to the other, may increase discrepancies

between self and social self (other people hate me) (Kinderman & Bentall, 2000), which is an expression of a more primitive defense, projection.

(ii) to show a smaller discrepancy between the self and ideal-self scores, equivalent to higher self-esteem.

(iii) to have *tighter* construct systems than those individuals with '*bad me*' paranoia.

(iv) to have less cognitively complex grids than the '*bad me*' group overall (but see point v).

(v) to have relatively more complex self constructs than other constructs in comparison to the 'bad me' group (i.e. the ratio [cognitive complexity for self constructs : cognitive complexity for other constructs] would be greater than the same ratio for the 'bad me' group).

(vi) to use less emotional constructs than the '*bad me*' group, given that sensitisers ('*bad me*' s) are less inhibited about accessing and using emotional terms.

(vii) to have relatively tighter organisation of self-constructs and looser organisation of constructs for other people, than for people with '*bad me*' paranoia.

It is worth noting that questions 2 (v) and 2 (vii) are mutually exclusive; both could not be true at the same time.

CHAPTER 2

METHOD

Overview

Twenty-two patients, who were identified as suffering from paranoid delusions were recruited from two mental health trust areas within Greater London. They were screened for adequate levels of vocabulary and for the presence of formal thought disorder. Those patients who were identified as having sufficient levels of vocabulary were given a measure to determine the general orientation of their paranoia (i.e. 'poor me' or 'bad me'). They were then given a measure of parental bonding before participating in a structured interview in which the participants' constructs were elicited and used to develop the measure of self-representation, the repertory grid.

Participants

Inclusion criteria

Having taken into account the most of the recommendations of Garety and Freeman (2000) for including people with persecutory delusions in a study the following criteria were used:

i. that the person had active persecutory beliefs that involved the idea of a person or persons intending to harm them.

ii. that they had *in the past* held beliefs that people had been intending to harm them and that at time of interview they maintained that this had been the case.

iii. that the delusional belief had to continue to cause that person distress.

Exclusion criteria

Those with poor literacy were excluded (see screening measures), and those who only had delusions of reference were excluded. Those participants who did not meet criteria for 'poor me' or 'bad me' paranoia, as described page 58 were also excluded i.e. they had to fit the description that Chadwick & Trower(1995) had outlined.

Recruitment

The participants were recruited slightly differently in each of the two health areas. In the first area, Consultant Psychiatrists were approached and asked to review their caseloads and identify anyone with paranoid delusions. They were provided with a general description of the two types of paranoia to assist them in selection of suitable participants. They were also given a patient information sheet outlining the nature of the tasks that they would have to complete (see Appendix I). The first nine participants were elicited from this first area. The refusal rate for this first area could not be determined because Consultants did not keep records of how many people were approached, and often, a patient was not approached because the Consultant thought that they were too unstable to participate in the study.

In the second health area, the researcher was allowed to approach health professionals from any discipline with a view to recruiting patients with whom they had contact. It was often the experience of the researcher that workers would unilaterally decide that a particular patient was not suitable for the study because they were considered to be too ill. Additionally, in the second health area, participants with a recent history of persecutory delusions (within the last year), who were also still outpatients of the mental health service, were also considered.

However, from those identified as suitable for participation, the drop-out rate for the first area was one out of twelve (8.3%) and two people out of that group (16.6%) of twelve was also considered to have inadequate literacy. This left a total of nine patients (75%) from the first area.

Of those patients recruited from the second health area, one person dropped out of a total possible of ten patients although this figure does not by any means reflect the true attrition rate.

It is also worth noting that there was some difficulty in engaging participants identified as having a 'poor me' paranoia, particularly in gaining their trust. For those identified as having a 'bad me' paranoia, the problem related to how difficult these patients found it to talk about themselves. This is reflected in the fact that the only person to have dropped out, *having initially agreed to meet with the researcher*, was considered to have a 'bad me' type of paranoia.

Participants filled in the questionnaires in the presence of the researcher who ensured that no items were missed out on each of the relevant measures and to assist in clarifying any questions or statements that they did not fully understand. Participants were seen in a variety of settings: psychology departments, Community Mental Health Teams (CMHTs) and the patients' own homes.

Ethical Considerations

Ethical approval for the project was granted by the two London NHS Trust Local Research Ethics Committees (see Appendix II).

Participants were given an information sheet prior to agreeing to take part in this study (see Appendix III). This sheet gave an outline of the study but couched in terms that were deemed acceptable to those patients who might not necessarily know that they were suffering from delusions i.e. had low insight. It reminded them that their participation in the study would not affect their treatment and that they were able to drop out of the study at any time. Following this, participants were given the opportunity to discuss the research more fully with the researcher. Participants were given the opportunity of receiving feedback about their responses both post interview and post analysis of results.

For patients in the first health area, they were reimbursed any travel expenses they incurred as a result of attending interviews. Those patients in the second health area were offered a flat fee of £10.

Design

The study used a cross-sectional group comparison design. Two separate screening methods were used to decide whether a person had 'poor me' or 'bad me' paranoia. The first was to look through the person's case notes, speak to relevant mental health workers who knew the patient and to talk to the patient himself, to find out the content of their delusions. On the basis of the content, the researcher made a decision as to whether they fell clearly into either of the two groups. The criteria for deciding to which group a participant belonged are given below. The second screening method was a questionnaire, the Plausible Scenarios Questionnaire (see below for details), which participants completed in front of the researcher. Responses on this questionnaire again determined which kind of paranoia a participant had: '*poor me*', '*bad me*' or both. These classifications thus formed the independent variables. Analyses for both kinds of classifications were performed. In addition, the extent of the overlap for the two classification systems was determined. The reason for using two classification systems was that the questionnaire measure had been

found to be unreliable in determining the kind of paranoia a person had during the data collection period, so a second method, based upon the content of the participant's delusions was introduced.

The next stage was to investigate whether the independent variable (type of paranoia) influenced the dependent variables in the ways outlined at the end of Chapter one i.e. did the 'bad me' group report significantly higher levels of overprotection than the 'poor me' group, and secondly, did the content and structure of the grids accord with the predictions set out in research question 2.

Measures

Screening measures

Literacy

As poor literacy levels are known to affect the interpretation of the tightness of a repertory grid, it was decided to screen for this using a simple measure of literacy, the *Mill Hill Vocabulary Scale* (Raven, Raven & Court, 1998 edition), (see Appendix IV). The junior version of the scale was administered to determine whether an individual's literacy was below a certain level. This test consists of two components, the vocabulary test and the synonym selection test. Only the second test was administered in order to save time and to reduce the demands made on participants with varying levels of concentration. It consists of thirty-three multiple-choice questions, where the participant has to choose one out of a possible six options synonymous with the target word. A cut-off score of 14 on the synonym selection test was used based on previous grid studies using this measure (Kirk, 1984).

Thought Disorder

Although one could have relied upon psychiatric assessments of the presence or absence of formal thought disorder, this was not always available. Additionally, thought disorder has been operationalised in a number of different ways and so the *Fransella and Bannister Grid Test of Schizophrenic Thought Disorder* (Fransella and Bannister, 1967) was chosen because it conceptualises formal thought disorder in terms of responses on a repertory grid task. Bannister (1960 & 1962) had found that people with schizophrenia who also had thought disorder tended to have poor inter-correlations between constructs on two separate administrations of a grid test, and furthermore, to have very different inter-relationships between constructs on a second grid. This test has been validated and is thought to discriminate reliably and validly, thought disordered people with schizophrenia, from non-thought disordered people with schizophrenia.

This test involves the administration of the same grid on two consecutive occasions. The grid uses supplied elements, which are six black and white photographs of men and women, and eight supplied constructs, which are 'kind', 'stupid', 'selfish', 'sincere', 'mean', and 'honest', always in that order. Participants were asked to rate each of these faces (elements) on each of these constructs by ranking the elements. Therefore the researcher would ask them which person they thought was the most 'kind' and keep doing so until all the faces had been ranked. Detailed instructions are supplied (see Appendix V).

Measures of Consistency and Intensity were calculated for each participant. Those who obtained scores of less than 700 for Intensity and less than 0.3 for Consistency were classified as formally thought disordered (see Appendix VI).

Categorisation into 'Poor me' and 'Bad me' paranoia

Two separate classifications were used in sorting participants. The first measure, the Plausible Scenarios Questionnaire (PSQ; Karoni, 1997; adapted by Maguire, Chadwick & Davies, 1999) was a measure of attributional style, and the second measure was based on the phenomenology of the presenting delusions (see below). It was entirely possible that the two classification systems were looking at different phenomena, so that someone with a 'poor me' paranoia may have been found to use 'bad me' attributions, and vice-versa.

The Plausible Scenarios Questionnaire

This measure was initially devised by Karoni (1997) to investigate attributional processes in people experiencing paranoid delusions, and was modified by Maguire et al. (1999) to include the 'poor me' and 'bad me' subscales (see Appendix VII). It has 10 vignettes describing everyday scenarios of minor misfortunes, such being given the wrong change in a shop. Each one of these is followed by six possible explanations for this misfortune: carelessness of the other, own fault, no blame/accident, malevolence (neutral; i.e. deliberate but not personal), malevolence ('poor-me'; i.e. deliberate but undeserved), malevolence ('bad-me'; i.e. deliberate and deserved). The participant is required to rate his/her strength of belief in each explanation on a 10-point scale (1 = definitely not true, 10 = definitely true). The range of possible scores for each subscale is 10 - 100. Cronbach's alpha (and standardised item alpha) values in a validation study of this measure (Juusti-Butler, 2000 – unpublished thesis) were as follows: 'carelessness' .85 (.85); 'own fault' .72 (.72); 'accident' .84 (.84); 'malevolence' .81 (.80); 'poor-me' .84 (.84); 'bad-me' .61 (.79).
Alpha coefficients were obtained for the 15 participants that completed this questionnaire, and these ranged from 0.66 to 0.85 with one subscale, carelessness possessing very low internal consistency (alpha = 0.43). The internal consistency for the 'poor me' and 'bad me' subscales were therefore considered adequate.

At the time this study was conceived the Plausible Scenarios Questionnaire was the only available measure for categorising the two groups of paranoia. Unfortunately Juusti-Butler (unpublished thesis, 2000) found that people classified as 'poor me' and 'bad me' on the basis of the content of their delusions, made both 'poor me' and 'bad me' kinds of attributions, as determined by the Plausible Scenarios Questionnaire, and therefore had low discriminant validity.

Participants were classified into 'poor me' or 'not poor me' based upon whether they fell above or below the median score for the 'poor me' subscale, and similarly for the 'bad me' subscale. The PSQ was not an effective way of sorting participants into the two types of paranoia, as has been mentioned above, however, the relationship between the four variables ('poor me', 'not poor me', 'bad me' and 'not bad me') was explored in relation to the dependent variables.

Classification based upon content of delusions:

In addition to using the PSQ, the content of participants delusions were assessed by talking to the participants themselves about their beliefs (if this was possible), reading medical notes (if they were available), and talking to case workers. The following criteria were used to determine which group each participant fell into:

For 'poor me' paranoia:

(i) They believed that a person or people were trying to harm them in some way.

(ii) They felt aggrieved by this as they had done nothing to deserve such treatment, they were hostile or fearful towards this person or group of people.

(iii) There was evidence of high self-esteem.

All of these criteria had to be met in order for someone to be classified as suffering from 'poor me' paranoia.

For 'bad me' paranoia:

(i) They believed that a person or people were trying to harm them in some way.

(ii) There was evidence of negative self-evaluation associated with the belief – e.g. "they know I'm such a bad person and that's why they're doing it."

(iii) There was evidence of low self-esteem.

Again, as above, all three criteria had to be met to allow someone to be classified as suffering from 'bad me' paranoia. These criteria were taken directly from Trower & Chadwick's (1995; p. 265-266) description of the two syndromes. For the 'bad me' classification, although it was logically possible for someone to have negative self-evaluative beliefs surrounding the delusion, and yet also have high self-esteem, Trower & Chadwick (1995) had not come across such people. The same might be said of the 'poor me' classification. Anyone who had that particular combination of symptoms would have been excluded from this study, because this study was particularly concerned with examining the two types of paranoia as Trower & Chadwick (1995) had described them.

Dependent variables

Assessment of parental style

The Parental Bonding Instrument (PBI; Parker, Tupling & Brown, 1979) was used to assess what kind of parenting experiences each participant had (see Appendix VIII). Each participant filled in the same questions for each of their parents. If a parent was absent then they were asked to choose a substitute figure. It consists of twenty-five items, which are descriptions of how the person's parent behaved towards them. Items are classified as referring to levels of care or overprotection.

Although it is a retrospective measure it has been found to be reliable and valid even after controlling for the effects of current mood state and social desirability (Parker, 1981; Brewin, Andrews & Gotlib, 1993). Pearson correlation coefficients for test-retest reliability, split-half reliability and inter-rater reliability were reported by Parker (1979) for the care scale as 0.761 ($P<0.001$), 0.879 ($P< 0.001$) and 0.851 ($P<0.001$) respectively and for the overprotection scale as 0.628 ($P<0.001$), 0.739 ($P<0.001$) and 0.688 ($p<0.001$) respectively . It has also been used successfully with a mentally disordered population (Parker et al., 1982).

It asks participants to recall their parents' attitudes and behaviours during their childhood (first sixteen years). Twelve of the items are associated with the giving of care and the thirteen remaining items are associated with over-protection. Each item is endorsed by the respondent as either *very like, moderately like, moderately unlike* or *very unlike*. Scores for each item range from 0 to 3 points, where 3 points is given for high care or high overprotection. For example, one of the items is "Let me do things I liked doing." If the respondent scored it as "very like" they would be given a score of 0 for overprotection. "Spoke to me in a warm and friendly voice," is a care item, and a score of 3 would be given

if the respondent endorsed "very like". Therefore high care scores signify optimal parenting along with low overprotection scores.

A maximum score of 36 and 39 can be obtained on the care and over-protection scales respectively. Patterns of response can be grouped into one of five categories: average; *optimal bonding* (high care – low overprotection); *absent or weak bonding* (low care – low overprotection); *affectionate constraint* (high care – high overprotection) and *affectionless control* (low care – high overprotection). Psychopathology, particularly depression has been associated with lack of care (Parker et al., 1979) as has overprotection, but to a lesser extent. There has been some dispute about whether a two-factor model or a three-factor model was more appropriate for interpreting the responses on this measure, the most recent article on this issue advocating a three-factor model: *care, denial of psychological autonomy* and *encouragement of behavioural freedom* (Murphy, Brewin and Silva, 1997). The two-factor model was used in this study because of established links between self-critical and dependent personality styles and these two variables of *overprotection* and low *care*. Scores lower than 27 on maternal care and 24 on paternal care, indicate a lack of care, and scores above 13.5 for maternal overprotection and 12.5 for paternal overprotection, indicate potentially harmful overprotection (Parker, Kiloh & Hayward, 1987).

Self-representation

This was assessed by a repertory grid, a tool commonly used within Personal Construct Theory as a means of looking at both the content and structure of a person's construct system, as developed from Kelly's (1955) Construct Role Repertory Test (Winter, 1992).

Each participant was presented with six supplied elements or roles and eight more elements were elicited from them. The six supplied elements were: *self, ideal self, self as others see me; self in one year's time; mother and father.* The eight elicited elements were: *someone I*

have been in love with; a friend; someone I like; someone I dislike; an employer who was easy to get along with; and an employer who was difficult to get along with. Thus making fourteen elements in total. Elements were chosen to be relevant to the domain of construal of self and other elements.

Fourteen constructs were elicited using the triadic difference method (Fransella & Bannister, 1977) in which elements were presented in groups of three and the participant asked in what way two of the elements were similar. There were asked if this was a positive or negative attribute. They were then asked 'with respect to this idea, in what way is the [third element] different?' If participants found this too difficult, they were asked for a word or phrase, which meant the opposite of the elicited construct. These two constructs were then placed at either end of a thirteen-point scale (from –6 to +6, with a midpoint of zero) depending on the valence allocated to each one of the constructs in the pair. Occasionally respondents would give a construct that was an either/or category, or give an overly specific attribute in which case they were asked if there was something about being an X or having an X (where X was the first attribute elicited) that made them different from other people (known as *laddering*).

A few participants had difficulty in working with the triadic method described, and in these cases, the interviewer (who was always the researcher) simply asked the respondent to describe that person as best as they could. For each idea or construct that the person came up with, the interviewer asked if this term could be applied to most of the people they knew in order to ensure an adequate range of convenience (Fransella et al., 1977). They were then asked to think of a person who did not have this attribute, and to say in what way they were different. If they found this too difficult, they were asked to think of the opposite of the first construct that they had produced. Again, as described above, constructs that were too superordinate or too subordinate were *laddered* by asking what it was about being or having X that made them different from other people.

It is worth mentioning that this concession to the varying intellectual abilities of the sample may have produced an additional artefact into the results. Hagans, Neimeyer and Goodholm (2000) found that asking people for the opposite of a supplied construct may produce less differentiation between constructs than when people are asked 'in what way is the third person different from the other two?'

The final stage of this structured interview involved the participant rating each of the chosen elements on the bi-polar construct scales that had been constructed from the second part of the interview. From this process, a fourteen elements by fourteen constructs grid of ratings was produced.

Analyses of the grids

The following measures were taken of the grids:

Tight construing – operationalised in terms of the variance accounted for by the first component of the grid (Slater, 1972, 1977).

Cognitive complexity – this was operationalised in terms of the number of agreements between each pair of constructs for each element. A score of 1 is given for each agreement, therefore, a higher score indicates a simpler grid and vice versa.

Distance between elements – e.g. self and ideal self, was operationalised in terms of the percentage agreement between ratings for each element.

These were carried out using a web-based package called Webgrid III (Gains & Shaw, 2000), a Dos-based grids analysis package called CIRCUMGRIDS, and SPSS using guidelines published by Bell (1995).

Procedure

Participants were initially asked if they had any questions about the information sheet supplied to them, and these were answered before they were given a consent form to sign (see Appendix IX). The researcher then asked them why they were receiving care from mental health services with the purpose of eliciting the delusional beliefs. If this line of questioning was not successful, they were asked if they had ever believed in something that others found difficult to believe, or if they had ever believed that people were trying to harm them. In most cases this elicited the delusional beliefs.

The above measures were administered in the order in which they are presented. Although the Grid Test for Schizophrenic Thought Disorder was used to determine whether a person could be considered to be exhibiting formal thought disorder, all of the dependent variables measures were administered to all of the participants, provided that they met the required literacy level. The reason for this being that it was not obvious whether someone met the cut-off on this measure of formal thought disorder without first making a lengthy calculation.

The administration of the entire battery was hardly ever possible in one sitting and due to some participants' limited attention spans, as many as four separate sittings were required, but these were always carried out within a two week period.

CHAPTER 3

RESULTS

This chapter will report the findings of the procedures outlined in the previous chapter. It will start by describing the sample more fully, before going on to describe the attrition rate for each stage of the research process.

Firstly, research question 1 will be explored, examining the relationship between type of paranoia by each method of categorisation, and scores on the Parental Bonding Instrument.

Secondly, the repertory grids will be analysed using the structural methods outlined in chapter 2, with a view to addressing the second set of research questions.

Thirdly, two case studies will be presented, one for each type of paranoia as determined by the content of delusions.

The Sample

A total of 19 participants agreed to take part from the two NHS Trusts. The mean age of these remaining participants was 39 years (range = 22 – 63), 14 of whom were male (10 'poor me' and 4 'bad me' based on the content of their delusions) and the other 5 female (2 'poor me' and 3 'bad me' based on the content of their delusions). A Chi-squared test was carried out to determine if the difference between numbers in the 'poor me' and 'bad me' groups was statistically significant, but this test showed

that this difference could have occurred by chance ($\chi^2 = 2.579$, df = 1, p = 0.108). In order to determine if men or women were over-represented in each type of paranoia, a Chi-squared test was carried out for the 'poor me' group ($\chi^2 = 3.769$, df = 1, p = 0.052), and for the 'bad me' group ($\chi^2 = 0.667$, df = 1, p = 0.414).

Table 1 gives details of each person's diagnosis, whether they were an inpatient or outpatient, whether they were on medication and a brief description of their delusions, along with the type of paranoia according to content and the kind of paranoid attributions they made based on a median split of this sample.

Description of the number of participants at each stage

Diagram 1 indicates the number of participants at each stage of the data analysis. The reason for showing this, is that two separate analyses were carried out for each of the two different ways of classifying participants into 'poor me' and 'bad me' paranoia. Note that the number of participants who were classified using the PSQ is only 15 due to the fact that this measure was not used on the last 4 participants due to its questionable validity. Nevertheless, it was decided to examine the differences between the two groups on this measure. The numbers in brackets indicate the number of participants at each stage of the analysis.

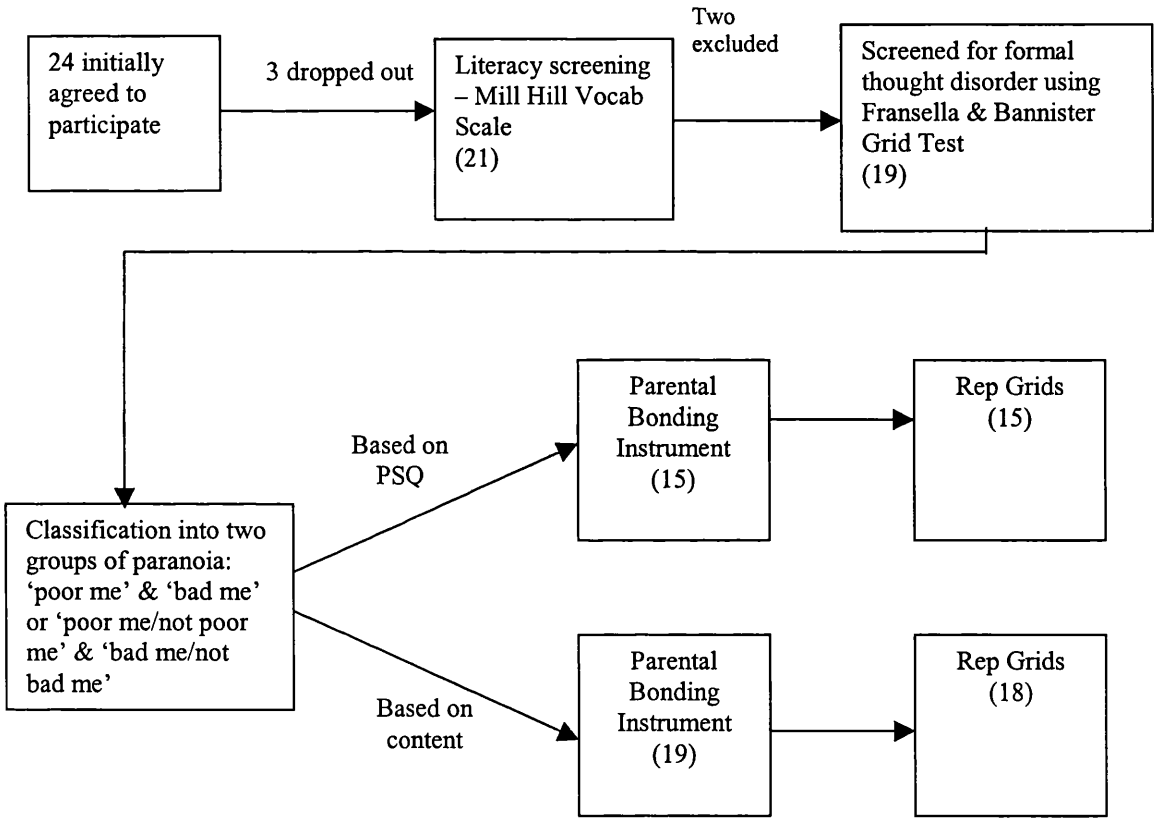
Table 1: Diagnosis, inpatient or outpatient status, medication status and brief description of delusion(s)

I.D.	Diagnosis	Inpatient or Outpatient	Medication	Content of delusions	Ethnicity / Nationality	Type of paranoia as determined by content	Type of paranoia as determined by PSQ
01	Paranoid schizophrenia	O/P	Yes	Other people think I am "bad" and "evil". Pop songs tell him this. Meek in interview. Although was beginning to be able to challenge the songs.	White British	BM	PM /Not BM
02	Paranoid schizophrenia	O/P	yes	People think I'm a homosexual and tell me that I'm going to die – messages from the radio. Doesn't believe what the voices say – unjustified persecution.	Asian British	PM	Not PM / Not BM
03	Paranoid schizophrenia			A group of people had been conspiring to hurt him by saying untrue, hurtful things behind his back.	Asian British	PM	N/a
04	Paranoid schizophrenia	O/P	No	A group of fellow workers were conspiring to harm him and subsequently he had a break down. Quite confident – tended to have quite high ambitions.	Asian British	PM	Not PM / Not BM
05	Paranoid schizophrenia	I/P	Yes	Long-term patient in her late fifties. No fixed delusions, but tended to be suspicious of others – strong feelings that people were against her.	White Spanish	PM	PM / BM
06	Paranoid schizophrenia	I/P	Yes	Very suspicious of others. In the past had strongly believed that aliens were trying to plant listening devices in his head which were harmful.	White British	PM	PM / BM
07	Paranoid schizophrenia	O/P	No	Had been feeling that someone was trying to kill him. The only explanation was in terms of him being evil.	White British	BM	PM / Not BM
08	Manic depressive psychosis	O/P	yes	Thought that her friends, neighbours and anyone close to her were trying to poison her. Still believed that this had been true but now no longer so.	White British	PM	N/a
09	Manic depressive psychosis	O/P	Yes	People hate her and want to hurt her because of wrong things she has done.	White British	BM	PM / Not BM
10	Manic depression	O/P	Yes	General feeling that people were out to harm her. Very low self-confidence and full of self-doubt.	White British	BM	BM / Not PM

I.D.	Diagnosis	Inpatient or Outpatient	Medication	Content of delusions	Ethnicity / Nationality	Type of paranoia as determined by content	Type of paranoia as determined by PSQ
11	Paranoid schizophrenia	I/P	Yes	Everyone's against him. People generally try and cause him distress and harm.		PM	BM / Not PM
12	Paranoid schizophrenia	I/P	Yes	General mistrust of others. He was outgoing but low self-esteem.	White British	PM	N/a
13	Manic depression	I/P	Yes	A conspiracy to get him out of his flat because his flat was worth a lot of money. They had driven him mad. Appeared confident.	White British	PM	Not PM / Not BM
14	Manic depressive psychosis	O/P	No	Someone trying to poison her. Very self-confident- contemptuous.	White British	PM	PM / BM
15	Delusional disorder – persecutory type	O/P	Yes	A very bad man is trying to kill him. Very unsure of self.	White British	PM	Not PM / Not BM
16	Paranoid schizophrenia	I/P	Yes	Neighbours are persecuting him. Appeared confident.	Afro-Caribbean British	PM	Not PM / Not BM
17	Paranoid schizophrenia	O/P	Yes	Believed that people were untrustworthy - they say bad things about her which she finds overwhelming and believable. Lacked confidence, very quiet and full of self-doubt.	Mixed race British	BM	BM / Not PM
18	Psychotic depression	O/P	Yes	Used to think that people were following him because of the bad (and shameful) things that he used to do. Still feels guilty and could not talk about the bad things he had done.	Black British	BM	PM / BM
19	Schizo-affective Disorder	O/P	Yes	Thought that people against her whilst studying abroad. This was not her fault, just about their prejudices.	Mixed race British	PM	N/a

Interpretation of PSQ ratings: Each participant who completed the PSQ (n=15), received *two* classifications based upon this measure: whether they were high or low for each subscale (i.e. PM or Not PM and BM or Not BM). See tables 2.1 and 2.2 for a summary of how the classification systems over-lapped.

Fig 1. Numbers of participants at each stage of data analysis



Screening for formal thought disorder

This was carried out using the Fransella and Bannister Grid Test for Schizophrenic Thought Disorder. Using a cut-off of 0.3 for consistency, and less than 700 for intensity. None of the participants met criteria for thought disorder (see appendix VI). Five of the participants had consistency scores below the cut-off. Separate analyses were carried out excluding these five people.

Classification into 'poor me' and 'bad me' paranoia

Two methods were used to classify participants as having either 'poor me' or 'bad me' paranoia. The first was based on scores on the Plausible Scenarios Questionnaire and the second on the content of delusions as assessed at interview and from medical notes. Originally, only the PSQ had been selected, but during data collection, an unpublished paper threw into question its reliability and validity (Juusti-Butler, 2000). Given the fact that participants had found the style of questioning repetitive and laborious, linked with the ever present issue of recruitment and retention, the researcher decided not to pursue this method. However, given the possibility that attributional style may also reflect a dimensional aspect to the 'poor me'-'bad me' distinction, the available data has been included in the analysis. Fig. 1. shows how two separate analyses were performed for each classification method.

Classification into 'poor me' and 'bad me' groups based upon content of delusions

A short description of the patient's delusion(s) was written down by the researcher based upon information acquired from interviewing the participant, conversations with mental health workers for that person, and their medical/clinic notes where these were available.

These descriptions were read by the researcher and one other psychologist, who independently made a decision as to whether that person had a 'poor me' or a 'bad me' type of paranoia.

A person was classified as having a 'poor me' type of paranoia if as well as believing that someone was trying to harm them (either physically or psychologically), the following two conditions were met:

(iv) They felt aggrieved by this as they had done nothing to deserve such treatment, and they felt hostile or fearful towards this person or group of people.

(v) There was evidence of high self-esteem.

A person was classified as having a 'bad me' type of paranoia if as well as believing that someone was trying to harm them (either physically or psychologically), the following two conditions were met:

(iv) There was evidence of negative self-evaluation associated with the belief – e.g. "they know I'm such a bad person and that's why they're doing it."

(v) There was evidence of low self-esteem, and especially shame (associated with behavioural avoidance of persecuting others).

Agreement for the two independent ratings was 100%. Six of the eighteen participants that completed a grid were classified as having 'bad me' paranoia, and the remaining twelve as having 'poor me' paranoia.

Classification into 'poor me' and 'bad me' groups based upon the Plausible Scenarios Questionnaire

A total of 15 participants completed this measure. As no norms were available to determine classification into 'poor me' and 'bad me' groups, a median split of scores was performed on the 'poor me' and 'bad me' sub-scales. This meant that 7 participants were classified as 'poor me' and 8 as 'not poor me', and similarly so for 'bad me' classification.

Tables 2.1 and 2.2 indicate the overlap of these methods of classification. Therefore, as highlighted in chapter 1, people who have 'poor me' paranoia make both 'poor me' and 'bad me' attributions, and similarly so for those who have 'bad me' paranoia.

Table 2.1 Overlap of classifying paranoia by content of delusions and by PSQ – Poor me sub-scale

	Category based on content of delusions	
Category based on PSQ ↓	Poor me	Bad me
Poor me	3	3
Not poor me	6	3
Total	9	6

Table 2.2 Overlap of classifying paranoia by content of delusions with PSQ – Bad me sub-scale

	Category based on content of delusions	
Category based on PSQ ↓	Poor me	Bad me
Bad me	4	3
Not bad me	5	3
Total	9	6

Tables 2.1 and 2.2 summarise the data presented in table 1, focussing on the overlap between classification systems. Therefore, each participant who filled in a PSQ would receive a rating on the PM subscale (table 2.1) and the BM subscale (table 2.2). What tables 2.1 and 2.2 fail to show is that some of the participants did not make any 'poor me' or 'bad me' attributions, as determined by higher than median scores on the relevant sub-scale of the PSQ (but see table 1). This might be due to the rather arbitrary way in which the cut-off was determined for this study, and that people who don't have paranoid beliefs may score much lower on these sub-scales as a matter of course. Additionally, it may be a reflection of the degree of conviction and pre-occupation with their delusions, which was not measured in this study. A total of five of the fifteen participants who completed the PSQ did not reach this threshold on either sub-scale. It may be significant that all five of these participants

were classified as having a 'poor me' type of paranoia, based upon the content of their delusions. This may be relevant in terms of a repressing coping style.

Research question 1

It was predicted that the 'poor me' paranoid group's responses on the Parental Bonding Instrument (PBI) would indicate a lack of care, and that the 'bad me' group's responses on this measure would indicate that they had experienced low care in combination with high overprotection, from at least one parent.

A comparison of absolute scores on the PBI was carried out for the two methods of classifying people into types of paranoia. Due to the small sample size and non-normal distribution, non-parametric statistics were used.

Reliability of PBI scores

Given the possibility that the 'poor me' group may have given a more positive view of their parenting experiences than the 'bad me' group, a reliability check was carried out comparing care and over-protection scores with ratings given for each parent on the grid. Although this would not necessarily detect such distortions, it was hoped that this would provide an additional check on the reliability of data given. The higher the total rating score for each parent, the more positively they were construed by that person. Spearman Rho statistics were calculated and are presented in table 3.0. The average number of negatively rated constructs for the 'poor me' group (based on content of delusions) was 2.9 for mother and 6.9 for

father, and for the 'bad me' group, 3.8 and 3.4 respectively. The mean rating on each construct for 'poor me' group was 9.4 for mother and 7.1 for father. The same figures for the 'bad me' group were 9.1 and 8.7. The maximum possible rating was 13. Scores below 7 indicate that a parent was negatively construed on that construct. Finally, a total score for all fourteen constructs was calculated (possible range = 14 – 196; a score less than half of 196 would suggest that a person tended to negatively rate their parent. The smaller the score, the more negative the rating becomes). This score was correlated with the scores on the PBI sub-scales and is summarised in table 3.

Table 3.0 Correlation between PBI subscales and Total grid scores for each parent

Type of paranoia	Grid element	PBI subscale	Correlation coefficient
Bad me	Mother	Maternal care	0.829*
		Maternal overprotection	-0.200
	Father	Paternal care	0.886*
		Paternal overprotection	-.486
Poor me	Mother	Maternal care	0.323
		Maternal overprotection	-0.765**
	Father	Paternal care	0.804**
		Paternal overprotection	-0.431

**** significant at the p ≤ 0.05 level (one-tailed). ** significant at the p ≤ 0.01 level (one-tailed)***

One would expect there to be a positive correlation between ratings of the element 'mother' in the grid, and maternal care scores, because a high care score on the PBI indicates a good relationship with mother. Similarly one would expect a positive correlation between the father element and paternal care scores on the PBI. Positive correlations are found for both types of paranoia, however for the 'poor me' group, the correlation is close enough to zero to warrant concern about correspondence between the two ratings. One would expect a negative correlation between ratings of

parent elements in the grid, and the appropriate parent sub-scale score for over-protection, because given high scores on overprotection one might expect that parent to be construed in a more negative way. Though this might not be the case if the person found it difficult to be critical of others, which one might argue is potentially part of the 'bad me' position. All the correlations are in the expected directions, however they are particularly weak for the 'bad me' group between ratings of the mother on the grid and ratings of maternal overprotection on the PBI. Might this suggest that people with 'bad me' paranoia find it particularly difficult to be critical of their mothers? There is a relatively weak correlation between the father element in the grid and paternal overprotection for both types of paranoia. Interestingly, there is a very strong negative correlation between ratings of the mother and maternal overprotection in the 'poor me' group, suggesting that this group do not find it difficult to criticise their mothers. Perhaps it is less threatening to admit that one's parent was overprotective than that they were neglectful. 85% of the men in the sample and 66% of the women reported low paternal care scores, using Parker et al.'s (1987) cut-offs. Low care scores on the PBI have been found to be highly predictive of depression in adulthood (Blatt et al., 1992, p.544).

Comparison of PBI scores between the two groups of paranoia based on content of delusions

Table 3.1. Median scores (and ranges) on the PBI for the two types of paranoia (based upon content of delusions).

PBI scale	'Poor me'	'Bad me'	Mann-Whitney U	P (one-tailed)
Mother				
Care	30.0 (33.0)	21.0 (32.0)	26.00	0.282
Overprotection	13.0 (33.0)	13.5 (17.0)	35.50	0.765
Father				
Care	8.0 (30.0)	13.0 (31.0)	31.50	0.521
Overprotection	15.0 (30.0)	13.0 (24.0)	29.50	0.416

Table 3.1 shows statistics for raw scores on the PBI. Although none of the differences were statistically significant, people in the '*bad me*' group tended to have lower care from their mothers. This difference was not predicted, however, this finding will be discussed in the light of the findings of parental attachment in the two kinds of depression (as explored in chapter 1) in the next chapter. The '*bad me*' group also reported slightly less overprotective fathers, which is in the opposite direction to that expected. It may be that the effect size is too small to notice with such a small sample. The same analyses were carried out excluding those participants identified as formally thought disordered (n=5) but none of the differences were significant either, the most significant difference was the 'bad me' group reporting lower maternal overprotection ($p = 0.217$).

Comparison of PBI scores between the two groups of paranoia based on PSQ scores

Two separate analyses were carried out based on participants' scores on the PSQ. First a comparison was made between 'poor me' s and 'not poor me' s, the findings

of which are summarised in table 4.1. Secondly, a similar comparison was made between 'bad me' s and 'not bad me' s, the findings of which are summarised in table 4.2. As can be seen from table 4.2, no significant differences were found between scores on any of the PBI sub-scales and the two kinds of paranoid attributional styles. However, table 4.1 suggests that people who tend to make '*poor me*' attributions, tend to have had more overprotective mothers, which is the opposite of the prediction. None of the comparisons were anywhere near significance when thought-disorder participants were excluded.

Table 4.1 Median scores (and ranges) on the PBI for 'poor me' and 'not poor me' groups as determined by PSQ responses

PBI scale	'Poor me'	'not Poor me'	Mann-Whitney U	P (one-tailed)
Mother				
Care	28.0 (22.0)	31.5 (33.0)	20.00	0.397
Overprotection	16.0 (20.0)	8.0 (22.0)	7.50 *	0.014
Father				
Care	22.0 (33.0)	6.0 (24.0)	17.50	0.232
Overprotection	12.0 (19.0)	18.0 (30.0)	17.50	0.232

**** Significant at p<0.05 (U=7.5, N_1 = 7, N_2 = 8, P = 0.014, two-tailed)***

Similar scores and statistics are reported in table 4.2 for the 'bad me' and 'not bad me' groups.

Table 4.2 Median scores (and ranges) on the PBI for 'bad me' and 'not bad me' groups as determined by PSQ responses

PBI scale	'Bad me'	'not Bad me'	Mann-Whitney U	P (one-tailed)
Mother				
Care	30.0 (32.0)	29.0 (25.0)	27.50	0.955
Overprotection	9.0 (22.0)	14.5 (25.0)	25.00	0.779
Father				
Care	11.0 (30.0)	11.0 (31.0)	27.00	0.955
Overprotection	16.0 (23.0)	11.5 (31.0)	22.50	0.536

Research Question 2

Each participant completed a repertory grid which involved them rating fourteen elements on fourteen elicited constructs. Each grid was analysed using a number of packages in order to derive a number of *structural* measures. In order to determine the tightness of a participant's grid, a principal component analysis was performed using software available on the World Wide Web, called Webgrid III (Gains and Shaw, 2001). In order to determine the cognitive complexity of each grid, a package called CIRCUMGRIDS was used, which calculates Bieri's statistic (Fransella & Bannister, 1977), cognitive complexity. Comparing the cognitive complexity of *self* versus *other* elements was done using SPSS, due to the fact that CIRCUMGRIDS was not able to calculate cognitive complexity for grids with fewer than six elements.

Research questions 2 (i) and (ii)

It was predicted that the poor me group would have a higher agreement between the way in which the self and social self were construed. Additionally, it was predicted that the 'poor me' group would also have higher self-esteem, as measured by a higher level of agreement between construal of *self* and *ideal self*.

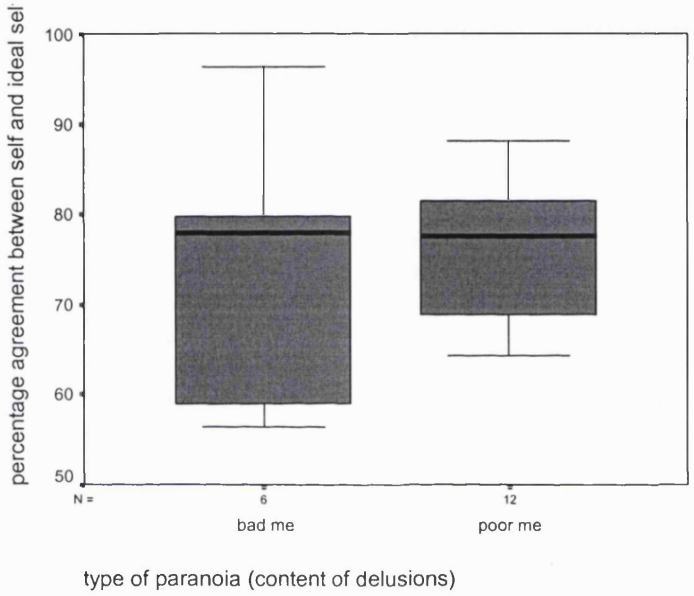
Average percentage agreement between elements was calculated using Webgrid III (Gains & Shaw, 2001). Therefore, if an element were construed in exactly the same **way** as another element, it would obtain a score of 100. None of the comparisons (tables 5.1-5.3) were significant, although given the vastly larger range of scores for the small 'bad me' group (n = 6), this suggested that either the variable "type of paranoia" would not show a difference in these dependent variables, or that this small *n* has been influenced by atypical outliers. Analyses excluding thought-disordered participants were even less significant. Analyses excluding formal thought disorder participants reduced the level of significance for distance between self and social self to $p = 0.067$, on the 'poor me' continuum of the PSQ. Similar analyses for the 'bad me' continuum on the PSQ showed a significant difference between the way between inter-element agreement ($U = 0.000$, $N_1 = 6$, $N_2 = 4$, $p = 0.01$) indicating that percentage agreement for construal of self and social self elements was greater for the 'not bad me' group.

Table 5.1 Median scores (and ranges) for percentage agreement in construal of self and social self elements and self and ideal self

Inter-element agreement	Poor me*	Bad me*	Mann-Whitney U	P (one-tailed)
Self and social	86.0 (23.2)	83.5 (45.2)	21.0	0.180
Self and ideal	77.7 (23.8)	77.9 (39.9)	30.0	0.616

****Based on content of delusions***

Fig 1.1 Percentage agreement between self and ideal self elements



The same comparison was carried out for the PSQ categorisations.

Table 5.2 Median scores (and ranges) for percentage agreement in construal of self and social self elements and self and ideal self.

Inter-element agreement	Poor me*	Not poor me*	Mann-Whitney U	P (one-tailed)
Self and social	83.9 (45.2)	87.2 (12.5)	5.50**	0.006
Self and ideal	75.0 (20.9)	80.7 (39.9)	12.0	0.072

****based on categorisation from PSQ ** Significant at P<0.01***

Table 5.3 Median scores (and ranges) for percentage agreement in construal of self and social self elements and self and ideal self

Inter-element agreement	Bad me*	Not bad me*	Mann-Whitney U	P (one-tailed)
Self and social	84.5 (10.4)	86.6 (51.2)	18.50	0.281
Self and ideal	75.0 (39.9)	80.1 (25.6)	23.5	0.613

based on categorisation from PSQ

A supplementary aspect to question 2 (i) was whether the element social self might be more simply construed by the 'poor me' group. The analysis in table 5.4 looked at this.

Cognitively complexity for the element social self was calculated by counting the number of agreements between each pair of constructs. The maximum figure for this would be the triangular number for 14 i.e. (n+ (n-1)+(n-2)....etc) if all constructs were given the same rating on this element. Higher scores signify greater cognitive simplicity, therefore the results are in the expected direction but not significant. When a similar analysis was carried out based on PSQ scores, neither comparison was significant ($p > 0.6$ for both analyses). Controlling for thought disorder no significant difference was found.

Table 5.4 Median scores (and ranges) for cognitive complexity of social self element for two types of paranoia (based upon content of delusions)

	Poor me	Bad me	Mann-Whitney U	P (one-tailed)
Range for social self element	15 (23)	10 (23)	19.0	0.377

Supplementary analysis

Given the large range of self-esteem scores for the 'bad me' group, and the observation that case study 2 (a case of 'bad me' paranoia) reported high maternal care, a multiple regression analysis was performed to determine the relative impact of the four scales on the PBI (maternal and paternal care and overprotection) plus type of paranoia (content) on self-esteem.

Using the enter method, a significant model emerged ($F_{3,14} = 3.348$, $p = 0.043$. Adjusted R square = 0.356) Significant variables are shown below:

Predictor variable	**Beta**	**p**
Maternal care	-0.681	$p = 0.006$

This showed that maternal care significantly predicted scores on self-esteem, independently of type of paranoia (based on content of delusions) and the PBI subscales, although surprisingly, a higher maternal care score predicted lower self-esteem.

Research question 2(iii)

It was predicted that the 'poor me' group would tend to have tighter construct systems than those individuals with 'bad me' paranoia. Tightness of construct systems was measured by the size of the principal component, as determined by a principal component analysis.

The principal component for each person's complete grid was calculated using the Webgrid III software.

Table 6.1 shows that the 'poor me' group did have marginally tighter grids overall, as indicated by a higher median score for the size of the principal component, however this could be due to chance. The tightness of grids for the people who tended to use 'poor me' style attributions was marginally in the opposite direction to the one expected, i.e. people who tended to make 'poor me' attributions as measured by the PSQ, also had slightly looser grids than those who didn't make 'poor me' style of attributions. However it is highly likely that this difference was due to chance. No significant differences were found when controlling for thought disorder.

Table 6.1 Median scores (and ranges) for size of principal component for people with 'poor me' and 'bad me' paranoia – as determined by content of delusions

	Poor me	Bad me	Mann-Whitney U	P (one-tailed)
Size of Principal component	63.5 (49.9)	58.8 (24.7)	27.0	0.44

Table 6.2 Median scores (and ranges) for size of principal component for people classified as 'poor me' and 'not poor me' paranoia – as determined by PSQ

	Poor me	Not poor me	Mann-Whitney U	P (one-tailed)
Size of Principal component	60.6 (49.4)	66.7 (25.9)	27.0	0.96

Table 6.3 Median scores (and ranges) for size of principal component for people classified as 'poor me' and 'not poor me' paranoia – as determined by PSQ

	Bad me	Not bad me	Mann-Whitney U	P (one-tailed)
Size of Principal component	68.5 (40.5)	57.7 (34.8)	23.0	0.61

Research question 2(iv)

It was proposed that the 'poor me' group would have cognitively less complex grids than the 'bad me' group.

A grid analysis package called CIRCUMGRIDS, a computer program written in DOS, was used to calculate cognitive complexity scores for the entire grids of each participant. The particular measure of cognitive complexity used here was based on Bieri's measure (Bieri, 1955). Comparison statistics are presented for the cognitive complexity of the whole grid for each type of paranoia for the two classification methods used. Lower scores indicate more complex grids, therefore the analysis suggests that the 'poor me' group had marginally more complex grids, though with such a high value for P, this difference is probably due to chance. None of the analyses were significant in tables 7.1-7.3 when thought disorder was controlled for.

Table 7.1 Median scores (and ranges) for cognitive complexity scores for people with 'poor me' and 'bad me' paranoia – as determined by content of delusions

	Poor me	Bad me	Mann-Whitney U	P (one-tailed)
Cognitive Complexity	315 (347)	439 (356)	21.5	0.51

Table 7.2 Median scores (and ranges) for cognitive complexity scores for people classified as using 'poor me' and 'not poor me' attributions based on PSQ

	Poor me	Not poor me	Mann-Whitney U	P (one-tailed)
Cognitive Complexity	378 (356)	315 (265)	16.0	0.53

Table 7.3 Median scores (and ranges) for cognitive complexity scores for people classified as using 'bad me' and 'not bad me' attributions based on PSQ

	Bad me	Not bad me	Mann-Whitney U	P (one-tailed)
Cognitive Complexity	378 (205)	315 (356)	15.0	0.45

Research question 2 (v)

The 'poor me' group were predicted to have more complex constructions of self as opposed to other elements, compared to the 'bad me' group.

The elements *self, ideal self, social self* and *future self* were selected as the self elements, and those remaining were the other elements. The analysis can be thought of as being carried out on two smaller grids, the first one consisting of four self elements by fourteen constructs, and the second, ten other elements by fourteen constructs. A Cronbach's alpha statistic was calculated using SPSS, which gives an equivalent measure to Bieri's measure of Cognitive Complexity (Bell, 1995). Using this method, the elements were treated as variables and the constructs as cases, which effectively gave a measure of the level of agreement between the construal of each element for self elements and similarly for other elements. As with usual measures of correlation, higher numbers indicate higher levels of agreement, and therefore lower cognitive complexity, and conversely, lower numbers indicate higher cognitive complexity. Having calculated Cronbach's alpha scores for each group of elements,

the score for other elements was subtracted from the score for self elements. This meant that a smaller (or negative number) indicated a more relative complex construal of self elements. Median difference scores are presented for the two types of paranoia, and for the four types of paranoid attributional style as measured by the PSQ, in table 8.1 – 8.3. The large range of differences for the 'poor me' group can be partially explained by two extreme outliers, one a relatively negative number (indicating greater relative complexity of construal of self elements) and the other a relatively larger positive number (indicating relatively less complex construal of self elements). A within-person's comparison for this measure of complexity of construal for self and other elements was not possible due to having much fewer self elements than other elements (Alpha gets larger with increasing numbers of items).

Table 8.1 Median scores (and ranges) for the relative cognitive complexity of construal of self to other elements for people with 'poor me' and 'bad me' paranoia – as determined by content of delusions

	Poor me	Bad me	Mann-Whitney U	P (one-tailed)
Cognitive Complexity	0.190 (3.199)	0.248 (0.841)	27.0	1.00

Table 8.2 Median scores (and ranges) for the relative cognitive complexity of construal of self to other elements for people who make 'poor me' and 'not poor me' attributions based on PSQ

	Poor me	Not poor me	Mann-Whitney U	P (one-tailed)
Cognitive Complexity	0.091 (1.410)	0.455 (2.183)	8.0	0.073

Table 8.3 Median scores (and ranges) for the relative cognitive complexity of construal of self to other elements for people who make 'bad me' and 'not bad me' attributions based on PSQ

	Bad me	Not bad me	Mann-Whitney U	P (one-tailed)
Cognitive Complexity	0.190 (1.815)	0.248 (2.225)	19.0	0.836

As can be seen from fig 2, those who tend to make 'poor me' style attributions based on responses on the PSQ, have lower relative complexity scores than those who do not make such attributions. A lower score indicated greater complexity, therefore, these results broadly support the hypothesis that the people who make 'poor me' style attributions have relatively more complex constructions of self-constructs than other-constructs. Even the outliers for the two groups in fig 2 are in the expected direction. This difference is approaching standard significance levels of $p \leq 0.05$. The reverse pattern of results should be obtained for those individuals identified as people who make 'bad me' style attributions versus those who do not. As can be seen from both table 8.3 and fig 3, there was little difference between the relative complexity scores for self and other elements for people who make 'bad me' style attributions as opposed to those who did not. None of the analyses attained significance when controlling for thought disorder.

Research question 2 (vi)

The 'poor me' group were predicted to use less emotional constructs than the 'bad me' group, given that sensitisers ('bad me' s) are less inhibited about accessing and using emotional terms.

The number of emotional constructs for used for each person's grid was determined by independent counts of emotional constructs, these being defined as either directly labelling an affective state e.g. fearful, or strongly implying an appreciation of an affective state e.g. caring. A score of one was given if either pole of the construct fitted the inclusion criteria for being an emotional construct. This meant that the

maximum score a person could have obtained was fourteen and the minimum score was zero. The researcher, and a second clinical psychologist carried out an independent count of such constructs, and Cohen's Kappa was determined as 0.96. Where there was disagreement, an average figure was taken when calculating the statistics below.

Table 9.1 Median scores (and ranges) for the number of emotional constructs used by people with a 'poor me' versus 'bad me' paranoia, based upon content of delusions

	Poor me	Bad me	Mann-Whitney U	P (one-tailed)
Number of emotional constructs used	4.0 (7)	5.5 (10)	18.5	0.100

Again, although this result is not significant, what difference is observable from fig 4 and table 8a is in the expected direction, with the outlier in the 'bad me' group having used a very large number of emotional constructs (twelve out of fourteen). It would be interesting to see if this difference was significant with larger numbers of participants

A similar analysis was carried out for the classifications based upon scores on the PSQ. The first comparison between people who made 'poor me' attributions versus those who didn't showed that the former group used marginally more emotional constructs on average, although this was not significant ($U = 18.0$, $N_1 = 7$, $N_2 = 8$, $p = 0.281$, one-tailed). This is in the opposite direction expected but could have occurred due to chance. The second comparison gave very similar results although this time in the expected direction, with people who made 'bad me' attributions using marginally more emotional constructs than those who did not ($U = 18.0$, $N_1 = 7$, $N_2 =$

8, p = 0.281, one-tailed). When controlling for thought disorder, the 'bad me' group based on PSQ were found to use significantly more emotional constructs than the 'not bad me' group (U = 2.000, N1 = 6, n2 = 4, p = 0.038)

Fig. 2. Difference between cognitive complexity scores for people who make 'poor me' style attributions versus those who don't, based on PSQ responses.

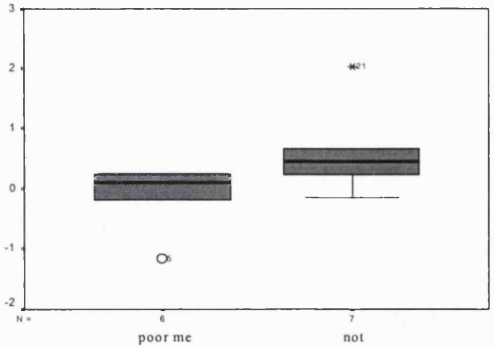


Fig 2.1. Difference between cognitive complexity scores for people who make 'bad me' style attributions versus those who don't, based on PSQ responses

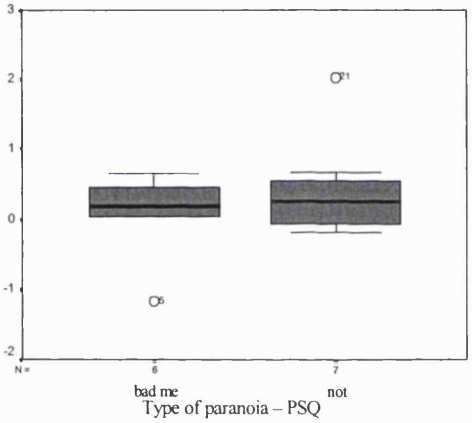
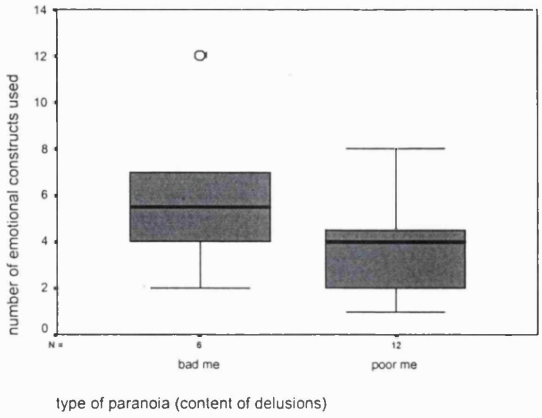


Fig 2.2. Comparison of the number of emotional constructs used by people with 'poor me' and 'bad me' types of paranoia, as determined by the content of their delusions



Research question 2 (vii)

The 'poor me' group were predicted to have relatively tighter organisation of self-constructs and looser organisation of constructs for other people, than for people with 'bad me' paranoia.

Tightness was measured by carrying out a principal component analysis for two grids abstracted from the main grid for each participant, one for self elements (self, ideal self, social self and future self) and one for other elements (the remaining ten elements). Again Webgrid III (Gains & Shaw, 2001) was used for this. Comparisons between tightness of construal of self elements and a separate comparison for other elements was carried out for between the groups of paranoia based on content of delusions and PSQ scores. Mann Whitney's were also performed on the differences between the two principal component percentages (which was the index of relative tightness of construing of self compared with other elements). None of these were anywhere near significant, for either classification method.

Table 10.1 Median (and ranges) for size of principle component for two types of paranoia based upon content

	Poor me	Bad me	Mann-Whitney U	P (one-tailed)
Size of principal component for self elements	75.3 (39.5)	82.6 (32.2)	22.0	0.213
Size of principal component for other elements	62.1 (35.6)	71.3 (48.8)	24.0	0.291

Table 10.2 Median (and ranges) for size of principle component as determined by the 'poor me' dimension on the PSQ

	Poor me	Not poor me	Mann-Whitney U	P (one-tailed)
Size of principal component for self elements	71.0 (35.6)	81.3 (44.1)	22.0	0.536
Size of principal component for other elements	69.9 (45.4)	69.6 (42.1)	27.0	0.955

Table 10.3 Median (and ranges) for size of principle component as determined by the 'bad me' dimension on the PSQ

	Bad me	Not bad me	Mann-Whitney U	P (one-tailed)
Size of principal component for self elements	81.9 (35.0)	77.1 (44.7)	24.0	0.694
Size of principal component for other elements	70.0 (48.8)	65.7 (38.7)	21.0	0.463

Case studies

Two cases will be presented, one for each type of paranoia (based upon content of delusions).

Case 1 – a man with 'poor me' paranoia

This person, who shall be called John (not his real name), is participant number 15 listed in table 1. He had been on the run from someone whom he thought was trying to kill him for many years. This had taken him all over the country, and he had supported himself during this time by finding work, which he was well able to do, having been trained in a manual profession. He avoided particular places where he thought associates and friends of his persecutor might spot him. He had no other psychotic symptoms other than this very strong belief that someone was trying to kill him.

When the researcher met him, he had recently been started on atypical anti-psychotics which had enabled him to remain as an inpatient before being transferred to a supported hostel. Previous attempts to hospitalise him had resulted in him absconding out of a strong fear that he may have been found by his persecutor.

Based on the content of his delusions, he was classified as having a 'poor me' type of paranoia, however, his scores for 'poor me' and 'bad me' attributions on the PSQ came below the median level for the entire sample. As has been discussed earlier, this did not necessarily mean that his scores on these sub-scales were outside the

range of those expected from non-delusional people, as no normative data was available for the PSQ.

Parenting

John scored 33 out of a possible total of 36 for levels of maternal care, and 26 out of 36 for paternal care. He scored 0 for maternal overprotection and 6 for paternal overprotection. On his grid (see fig 5.) he construed his father and mother very positively, giving mean scores of 11.4 and 11.3 for each construct respectively. The highest possible mean score being 13.

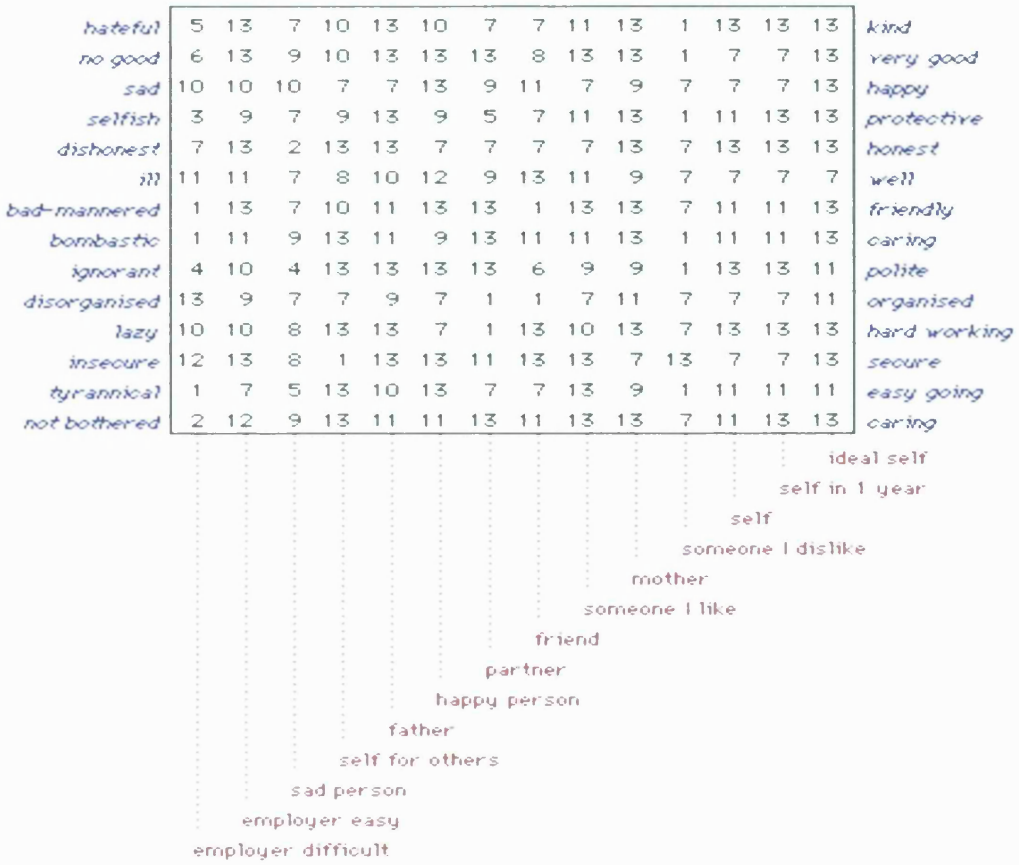
A cluster analysis using the Webgrid III Focus Clustering function, was carried out. Percentage agreement between construal of elements was calculated using this function.

Percentage agreement for construal of:	self and ideal self	81.0%
	self and social self	87.0%
	self and someone disliked	48.8%

In addition to the small difference between the way in which the self and ideal self were construed, John also construed himself positively in absolute terms, not giving himself any negative ratings on any of the constructs, however on the constructs insecure, ill, sad and disorganized, he had rated himself as zero, which strictly speaking means that he was saying that that construct does not apply to him, or perhaps that it did but he found himself unable to give himself a negative rating on any of these.

Repertory grid

Fig 3 Repertory grid for participant 15



Constructs are situated down the sides of the grid and elements are situated at the bottom.

Grid scores were converted to positive numbers for the purpose of the analysis, therefore, a rating of 7 is equivalent to a rating of zero (or not applicable to that element), and a rating below 7 is equivalent to a negatively rating on that for that element on a particular construct.

Fig 3.1 Map of principal components with elements (red text) and constructs (blue text) for person with 'poor me' paranoia

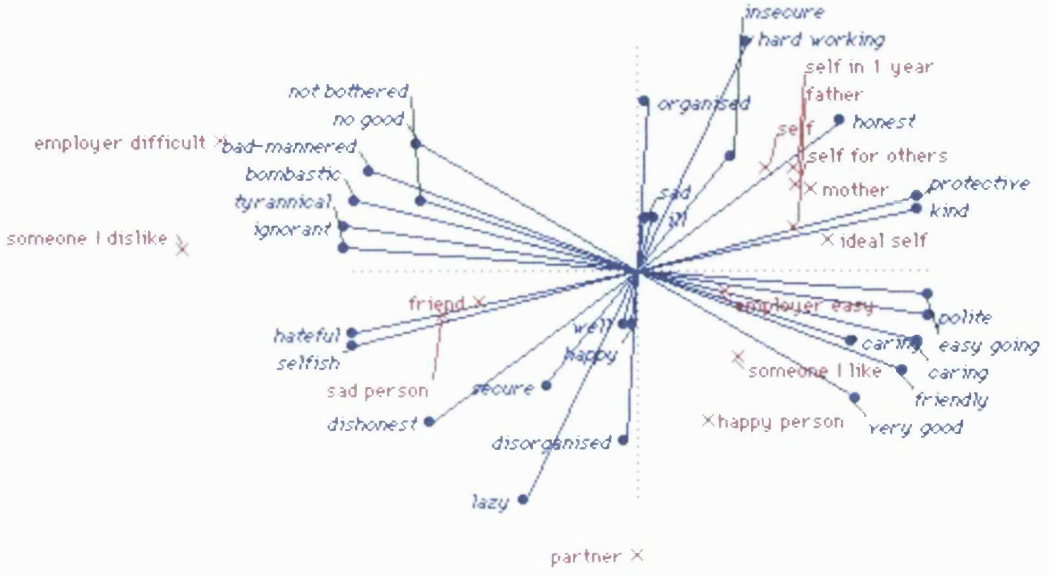
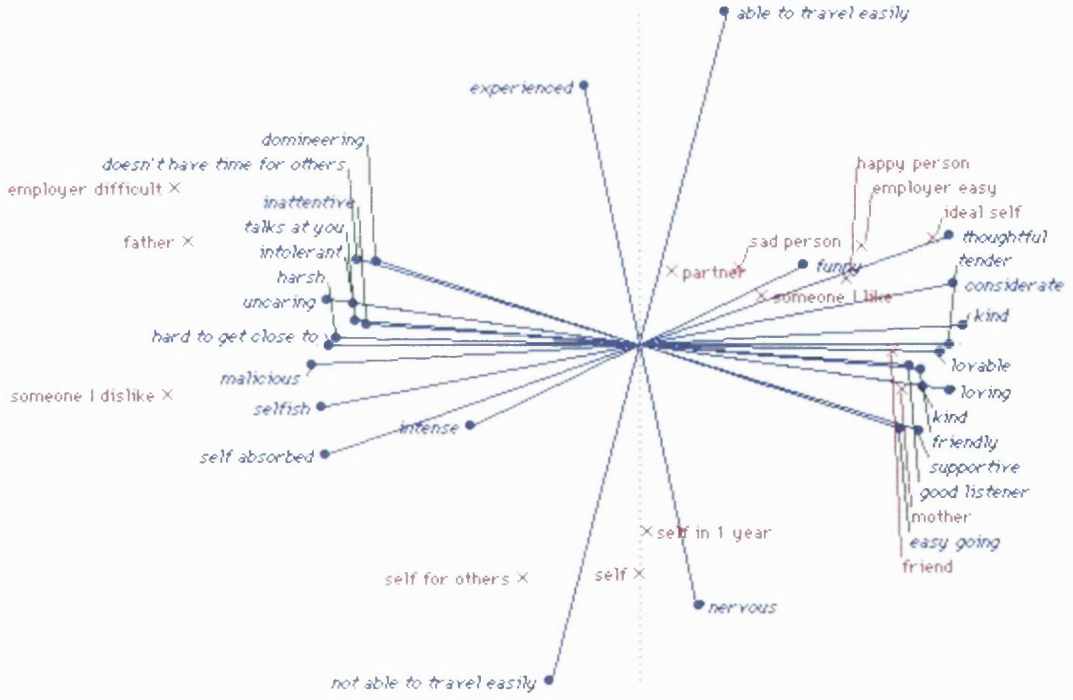


Fig 4.1 Map of principal components with elements (red text) and constructs (blue text) for person with 'bad me' paranoia



Summary

Although John fitted the profile for someone who had a 'poor me' style of paranoia, and in fact his levels of pre-occupation, and distress were considered to be very high, his scores on the PBI do not confirm that he had low care from either parent as would be expected for someone with 'poor me' paranoia; in fact quite the opposite was the case.

What was very striking about John was his complete and utter advocacy of non-violence, and his persecutor was someone described as a "very violent person." The story about his persecutor was closely tied to the break-up of a close relationship and this very violent person appeared to be a projection of his angry feelings. John's inability to give him*self* negative ratings on any of the constructs, particularly "ill" supports the idea that he may have been using a repressive strategy. This perhaps is an illustration of a self-serving bias: he was much more willing to believe in his paranoid belief than that he might be ill, although given this construct had been elicited from him suggests being ill or well are foremost in his mind. Very high agreement between construal of self and ideal self elements is consistent with a 'poor me' profile. The size of the principal components for self and other elements was 75.6 and 58.3 respectively, which reinforces the idea that threat to self is coped with by constriction. The similarity between his construal of self and future self (self in one year) is perhaps suggestive of depression, especially given that there is no difference on the more negatively rated constructs e.g. "ill".

The other interesting aspect of John's grid, as is illustrated in figure 5.1, is his construal of himself on dimensions that one might associate with both attachment (protective,kind and perhaps insecure?) and intrapersonal qualities (honest).

Case 2 – a woman with 'bad me' paranoia

This person, who shall be known as Janet (not her real name) is case number 10 in table 1. Her paranoid beliefs were more diffuse than John's in that not a single person or group of people were persecuting her, but that the vast majority of people were doing so. This was manifested in a very real sense for her of people being against her in all sorts of different ways, and she had various anecdotes illustrating this general perception. This sense of being persecuted was also felt in relation to the researcher, and it took considerable efforts on the part of the Clinical Psychologist who was seeing her in a therapeutic capacity to see the researcher. Janet finally agreed to see the researcher, provided that her Clinical Psychologist was also present. After the first meeting with the researcher she was able to see him without her therapist being present.

Unlike John, Janet was well educated and had worked in a profession which had demanded good cognitive functioning.

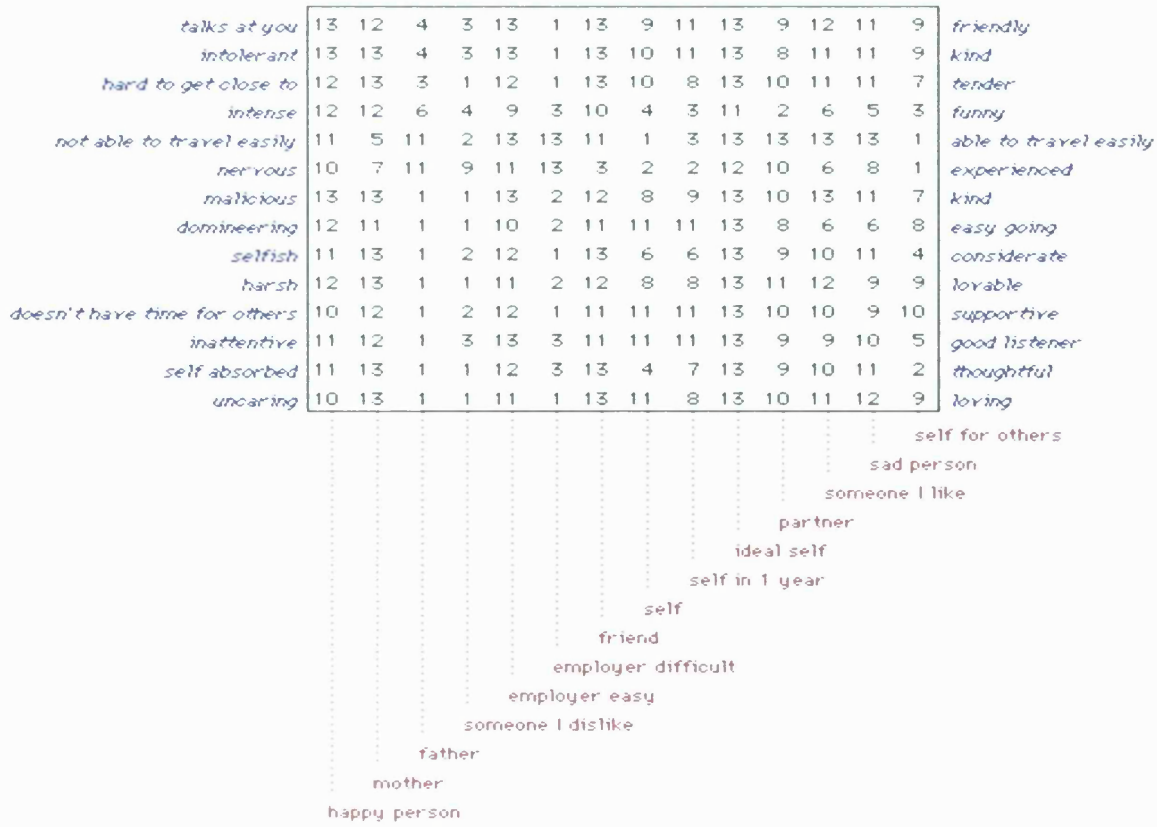
Based on the content of her delusions she was classified as having a 'bad me' type of paranoia. She also scored higher than the median score for the entire sample on the 'bad me' sub-scale of the PSQ.

Parenting

Her score on the maternal care scale was 35 out of 36, and 3 out of 36 for the paternal care scale. Her scores for maternal and paternal overprotection were 9 and 27 respectively. The scores for the mother indicate optimal parenting, however, the scores for the father indicate a lack of care and couple with an over-controlling style of parenting, which supports the first research question.

Repertory grid

Fig 4 Repertory grid for participant 10



Percentage agreement for construal of:	self and ideal self	56.5%
	self and social self	85.7%
	Self and someone disliked	47.6%

Unlike John, Janet construed herself negatively on five constructs: she sees herself as self-absorbed (-3), selfish (-1), nervous (-4), unable to travel easily (-6), and intense (-3).

There seems to be good correspondence between this person's PBI score and the ratings she gave to her father, who is construed very negatively on most of the constructs in her grid.

As can be seen from fig 6.1, Janet construed herself as someone who was nervous and did not travel easily, and both *herself in one year* and *self* as perceived by others is very similar, perhaps suggesting low optimism about changing this and stating the 'bad me' position on those two constructs anyway i.e. "I'm bad and other people can see that"

Summary

Janet's scores on the PBI for her indicated low levels of care and high levels of overprotection from her father, as predicted by 'bad me' paranoia being a defense against a self-critical kind of depression. Also in keeping with the 'bad me' formulation was her negative construal of herself on five of the fourteen constructs

and the low levels of agreement between construal of the self and ideal self (the lowest level for any of the 'bad me' group).

However, she was able to see good aspects to herself (tender and kind), which may have been partly due to her mother's good parenting and partly due to her involvement with the clinical psychologist, whom she insisted on being present whilst I interviewed her. Perhaps significantly, the researcher was male and her psychologist female. The percentage agreement between the elements *self* and *person I dislike* was quite small, which suggested that she was on the road to seeing herself in a more positive light, and has been found to be small in people recovering from depression (Space, Dingemans & Cromwell, 1983)

CHAPTER 4

DISCUSSION

This was an investigation into the both the nature of self-representation in 'poor me' and 'bad me' paranoia, and the developmental origins of these two kinds of paranoia. It specifically focussed on whether the consequences of the defensive styles of the two groups would predict the structure and content of their construct systems. In addition it predicted that these two groups would be distinguished by their responses on the Parental Bonding Instrument (PBI; Parker et al., 1979), a measure of remembered parenting.

It was hypothesised that people with the two kinds of paranoia, would report different patterns of parenting that they had experienced. This was examined with the PBI, which looked at peoples' responses in terms of whether they were adequately cared for and whether or not they were overprotected. It was predicted that both kinds of paranoia would be associated with low care scores and that in addition, the 'bad me' group would report high overprotection scores.

Secondly, specific differences in the personal construct systems of the two groups of paranoia were explored using repertory grid technique. Particular differences in the structure and content of their grids were considered in the light of the differences in the two groups highlighted by Trower & Chadwick (1995). They were also considered by drawing comparisons between the defense mechanisms of the two types of paranoia and the two broadly defensive strategies highlighted in the literature on perceptual defence.

Summary of Findings

A total of 22 participants agreed to take part in the study, however 2 did not have adequate reading ability and another dropped out after completing the Fransella and Bannister Grid Test. This meant that a total of 19 participants were compared on the basis of their responses on the PBI and completion of a 14 element by 14 construct repertory grid.

The sample

Smith, O'Keefe and Jenkins (1988) had found that dependent males and self-critical females had a *heightened* vulnerability to depression triggered by interpersonal loss and achievement respectively. On this basis, one would expect to find more men in the 'poor me' group (which is considered to be a defence against a dependent kind of depression) and more women in the 'bad me' group (which is considered to be a defence against a self-critical kind of depression). 77% of the 'poor me' group, classified by the content of their delusions, were men, and 33% of the 'bad me' group were women. Based on these figures, only the first of Smith et al.'s (1988) distinctions was borne out in this sample i.e. men were over-represented in the 'poor me' group. The fact that there weren't more women in the 'bad me' group either refutes their finding or, means that the sample is not representative of the 'bad me' group. It is also worth noting the small sample size which makes the proportion of men to women in each group more vulnerable to chance variation.

Another potential problem with this sample may have been due to the effects of sampling bias. As Garety & Freeman (2000) pointed out, people who have higher levels of conviction or pre-occupation, and those who are more emotionally distressed by their beliefs, are less likely to agree to participate in such a study.

Another sampling error may be produced by the difference in defensive styles of the two kinds of paranoia. People with 'bad me' paranoia are described by Trower & Chadwick, as tending to avoid other people in order to avoid the experience of being overwhelmed and constituted by the other. In the experience of this researcher it was harder to persuade the 'bad me' group to participate than the 'poor me' group. People with 'bad me' paranoia were usually only contactable because they were in close contact with a trusted mental health worker who actively supported them to participate in this study. Even though more people with 'poor me' than 'bad me' were recruited, this difference could well have occurred by chance. However, this does not necessarily disconfirm the possibility that such a selection bias was occurring, it simply does not confirm it.

The idea that the 'bad me' group may be more difficult to recruit is supported by a finding by Drayton, Birchwood and Trower (1998). They found that people with schizophrenia who endorsed more negative self-self evaluations of the Evaluative Beliefs Scale (EBS), were more likely to use a 'sealing over' recovery style (as measured by the Recovery Style Questionnaire - RSQ, developed by the authors). Thus in effect people with what appeared to be a 'bad me' presentation, were more likely to avoid discussing their experiences of illness after an acute episode.

The other sampling issue regards establishing measurable thresholds that could indicate whether someone was in fact symptomatic at the time of assessment. It was this researcher's experience that some participants showed low pre-occupation but high conviction (Brett-Jones, Garety & Hemsley, 1987) as indicated by people who believed that someone had been trying to kill them but was no longer continuing to do so, although this variable was not formally assessed. As Garety & Freeman (2000) suggest, the salient variable here may well be pre-occupation and future threat, which one might expect to be associated with the activation of negative self schemata which have been implicated in the paranoid delusions (Bentall et al., 1996).

Achenbach, McConaughy and Howell, (1987) and Madsen (1992) both noted that concordance between expert-ratings of symptoms and those based upon self-report measures tends to be very low. Dozier and Lee (1995) noted that this may in part be due to the discrepancy between dismissing attachment styles and preoccupied attachment styles. They proposed that individuals with a dismissive attachment style might be under-represented both in terms of un-reported psychopathology and in terms of representation within samples in studies of psychopathology. Clearly this presents problems for a study such as this, although one might expect the 'poor me' group rather than the 'bad me' group to adopt such a style, and the former were perhaps over-represented, although this would assume equal representation of the two groups in the general population. However, given the findings of Drayton et al. (1998) that a 'bad me' style of presentation was associated with a sealing over style of recovery, perhaps both groups are equally disposed to avoid participation in such a study as this one. The link between attachment styles and type of paranoia has yet to be established.

***Research question 1*: People with 'poor me' paranoia would report neglectful or absent parenting, whilst people with 'bad me' paranoia would report critical and controlling parenting.**

With respect to participants' responses on the PBI, when Parker's (1983) cut-off scores were used, a majority of people indicated that they had received low levels of care from their fathers (85% of the men and 66% of the women).

Comparison of raw scores on the PBI for the two types of paranoia, as determined by the content of their delusions gave no significant differences between the 'poor me' and the 'bad me' group on either the care or overprotection sub-scales for either parent of the PBI. Both groups were expected to have low care scores, although, the 'bad me' group had lower

maternal care scores than the 'poor me' group. The 'bad me' group also had slightly less overprotective fathers. Although scores for maternal overprotection for the two groups were not significantly different, the range of scores for the 'poor me' group was about twice that of the 'bad me' group. The 'poor me' group reported slightly lower paternal care scores. None of these differences were statistically significant, but for small effect sizes, much larger sample sizes would be required to detect differences between the two groups.

For the fifteen respondents who completed the PSQ, one could only ever draw conclusions about those people who tended to endorse with higher levels of conviction 'poor me' or 'bad me' style attributions. The most that this data could reveal, was that people who had greater conviction in 'poor me' or 'bad me' attributions, reported differences in parenting experiences. People who were classified as 'poor me' reported significantly more maternal overprotection than the 'not poor me' group. This is in the opposite direction to that expected, and differs from the finding based on classifying people into 'poor me' and 'bad me' based on the content of their delusions, when no difference was found between the two groups on maternal overprotection. There was also a non-significant trend towards the 'poor me' group reporting higher paternal care and lower paternal overprotection. The latter finding is in the expected direction stated in the first research question. On the 'bad me' subscale of the PSQ, none of the care or overprotection scores were significantly different for either parent. Paternal overprotection was marginally higher in the 'bad me' group, although this was reversed for maternal overprotection, the 'not bad me' group reporting marginally more of this.

Research question 2: ***How do the personal construction systems differ between people who have 'poor me' paranoia and those who have 'bad me' paranoia?***

Distance between social self and self elements

The first question was linked to examine the proposal that the 'poor me' group would resemble people who used denial as a coping strategy (Catina, 1992). On this basis high percentage agreement for construal of these two elements was expected., for the 'poor me' group in comparison to the 'bad me' group. The 'bad me' group were thought to resemble people who used rationalisation as a defense, in that like sensitisers, they too more readily endorsed negative self-evaluations. A non-significant trend was found in the expected direction.

The same comparison was carried out for classification based on PSQ scores. Contrary to expectations people who had less conviction in their endorsement of 'poor me' attributions gave grid responses indicating lower agreement between these two elements. The results based upon the 'bad me' continuum agreed with expectations, in that those who showed greater conviction in endorsing 'bad me' attributions on the PSQ also construed themselves less similarly than their social selves.

Construction of self and ideal self elements (self-esteem)

The 'poor me' group were expected to have a higher self-esteem, as indicated by higher percentage agreement between construal of self and ideal self elements. Based on content of delusions, the 'poor me' group did not have significantly higher percentage agreement for construal of these elements. Based on PSQ scores, there was a non-significant trend towards the 'poor me' group having obtaining scores consistent with marginally lower self-esteem. This is in the opposite direction to that expected. No difference was found on the 'bad me'

continuum. A multiple regression showed that higher maternal care predicted lower agreement between self and ideal self construal, independent of type of paranoia, and of the other PBI subscales.

Tightness of construing for whole grid

Assuming that a comparison between the defensive style of the 'poor me' group and the defensive style of repression was warranted, the former were expected to have more tightly organised constructs than the 'bad me' group (Catina et al., 1992). Classification based upon content of delusions showed a non-significant trend for the 'poor me' group to have tighter grids. Categorisation based upon PSQ scores showed no difference between 'poor me' and 'not poor me' groups, likewise for the 'bad me' continuum.

Cognitive complexity of entire grid

Given that repressors have cognitively less complex grids (Wilkins et al., 1972), and that the 'poor me' group might resemble them, the 'poor me' group were also expected to have less complex grids. Contrary to expectations, based upon content of delusions, the 'poor me' group were shown to have marginally more complex grids, however this difference was not even closely approaching statistical significance. Similarly inconclusive findings applied in terms of classification by PSQ.

Cognitive complexity of self and other constructs

The 'poor me' group were predicted to have more cognitively complex constructions of *self* as opposed to *other* elements, compared to the 'bad me' group. The reason for this was that the 'poor me' group would be expected to have more meaningful constructions of themselves than the 'bad me' group. In PCT terms, more meaningful clusters of constructs would have higher levels of differentiation or cognitive complexity, because the cluster has to be better at predicting a multitude of events (Winter, 1992). Classification into the two types of paranoia based upon content of delusions, showed no significant difference between the cognitive complexity of self constructs for the 'poor me' group over the 'bad me' group. However, based on scores obtained on the PSQ, people classified as 'poor me' had cognitively more complex self constructs than the 'not poor me' group which was approaching significance. There was no difference for this comparison between the 'bad me' groups.

Use of emotional constructs

The 'poor me' group were predicted to use less emotional constructs, based upon the assumption that they were more likely to resemble the profile of someone classified as a repressor. Based upon classification by content of delusions, there was a non-significant trend in the expected direction, with the 'bad me' group using more emotional constructs than the 'poor me' group. Conflicting results were obtained when a similar comparison was carried out based on PSQ scores. In support of the hypothesis, the 'bad me' group used marginally more emotional constructs than the 'not bad me' group. However, the 'poor me' group also used marginally more emotional constructs than the 'not poor me' group.

Tightness of Self and other constructs

The 'poor me' group were predicted to have more tightly organised constructs for self elements than other elements in relation to the 'bad me' group. In fact the 'bad me' group demonstrated tighter construing in absolute terms for both self and other elements treated separately, although no difference was found for the relative tightness of self and other elements. Based upon the PSQ those who tended to make 'bad me' attributions generally construe themselves more tightly if they had greater conviction in endorsing these. Also, tightness of construal for both self and other elements was greater than for those who were classified as making 'poor me' style attributions.

Interpretation of Findings

Scores on the PSQ

What the scores on the PSQ suggested was that the tendency to make 'poor me' and 'bad me' attributions was not exclusive to people who have as a central theme 'poor me' and 'bad me' type of persecutory delusions. This of course makes it a very poor tool for dividing people with persecutory delusions into 'bad me' and 'poor me', however given the potential multi-representational nature of the self and internal working models of attachment, one might even begin to question the usefulness of such a distinction.

High scores on the PSQ for these paranoid attributions, may be determined by response biases. Individuals high on repression may tend to give lower endorsements for distressing attributions (e.g. Dozier et al., 1995). Therefore, one might expect the 'poor me' group to give lower conviction ratings on the PSQ. This indeed appeared to be the case, with five people in the 'poor me' group giving lower ratings than the median score for the fifteen

participants who completed this measure. Therefore, in Trower et al.'s favour, this measure was probably measuring more than just a tendency to make particular kinds of paranoid attribution.

Parental Bonding

People with 'bad me' paranoia were expected to have more overprotective parents than people with 'poor me' paranoia. The 'bad me' group reported slightly less overprotective fathers, although this was not significant, and no difference was reported on levels of overprotection from mothers.

This finding can be explained on a number of grounds. Firstly, there is the issue of sampling error, perhaps only those people with 'bad me' who were less pre-occupied with negative self evaluations were able to find the strength to participate in the study. This is perhaps supported by the finding on the repertory grid data, that there was no significant difference in levels of self-esteem, as determined by the percentage of agreement for construal of *self* and *ideal self* elements. If such a sampling error occurred, the question would then be, would the 'bad me' group be more effected by this than the 'poor me' group? On the assumption that the 'bad me' group are more likely to use behavioural avoidance than the 'poor me' group, then the answer would be yes. Then there is the possibility that the 'bad me' group might present a false self, however Drayton et al. (1998) had shown that people with schizophrenia who endorsed negative self-self evaluations also reported lower care scores on the PBI. It is unlikely that an opposite kind of sampling bias could account for their findings.

Secondly there is the issue of the specificity of parenting experiences mapping onto the two kinds of depression that these types of paranoia are supposedly defending against. The case for the level of specificity stated by Trower & Chadwick (1995) is far from conclusive. For example, the McCranie and Bass (1984) study which found women who were rated as

having a dependent style of depression, based upon responses on the DEQ, reported dominant and controlling mothers, not neglectful and absent ones. Based on evidence from the differential effects of subliminal messages on people identified as having dependent or self-critical personalities, Blatt et al. (1992) concluded that these two groups were broadly speaking affected in the ways predicted. However, in their review of this literature, they noted that the self-critical group was just as vulnerable to messages designed to produce fear about object loss e.g. "I am all alone", as they were to messages designed to produce guilt over separation and individuation e.g. "leaving Mom is wrong." This lack of specificity is perhaps borne out in the responses on the PSQ for the two groups. Participants responses on the Plausible Scenarios Questionnaire demonstrated what Juusti-Butler (2000) had also found, that people with 'poor me' or 'bad me' paranoia tended to make both 'poor me' and 'bad me' attributions. In fact, the 'bad me' group in this study made a greater number of 'poor me' attributions than the 'poor me' group. This seems to support the idea that a self-critical kind of depression (thought to be a defended against by 'bad me' paranoia) has much lower specificity as reported by Blatt et al. (1992) who noted that such individuals expressed concerns about interpersonal loss and failure. It could also reflect a sensitising approach on the part of people with 'bad me' paranoia.

Thirdly, there is the possibility that the 'poor me' group, thought to be defending against a dependent kind of depression, might not report negative parenting experiences on the PBI because the parental representations have been found to be at a lower developmental level for dependent depressed individuals than for self-critical individuals (Blatt et al., 1979). This might explain why the 'bad me' group did report marginally lower maternal care than the 'poor me' group. It would not necessarily explain the marginally higher paternal overprotection scores for the 'poor me' group, unless as is suggested below, such experiences are not perceived as threatening to them.

Fourthly, there is the potential that people with 'poor me' paranoia have a tendency to use a repressive style of coping that would result in under-reporting of parenting experiences that would be experienced as intra-psychically threatening. However, the 'poor me' group did report slightly higher levels of paternal overprotection, though it is possible that this was less threatening to them, especially if their pre-occupation is with maintaining attachments – the experience of being overprotected may well be positively construed or experienced. On the other hand, as mentioned previously, Drayton et al., (1998) found an association between people with schizophrenia who had a 'bad me' presentation (reflected in their greater endorsement of negative self-self evaluations on the EBS) and low care scores for both parents. More interestingly, they found that both the sealing over group (the 'bad me' s) and the integrative group had affectionless, controlling parents (low care/high overprotection) as measured by the PBI. However, the difference between the two groups on the PBI was the level of care reported which was much lower in the people who used the sealing over recovery style. Although these authors were not looking at the distinction between 'poor me' and 'bad me' paranoia as such, this finding is in accordance with the current finding. Their study also suggested that despite the tendency of the 'bad me' group to utilise a 'sealing over' style of recovery from psychosis, this does not adversely effect outcomes on self-report measures of remembered parenting.

The most significant trend, although still not statistically significant, was that the 'bad me' group reported lower maternal care scores. Could it then be that the one crucial difference between the two groups of paranoia, is that the primary care-giver, who is more often than not the mother in most cultures, is uncaring and neglectful producing a dependent kind of depression in the 'bad me' group, and that what protects the 'poor me' group from having a fragile ego or to use Trower et al's (1995) terms, an *alienated self*, is a caring mother? Five out of the total of thirteen people with 'poor me' paranoia reported optimal parenting (high care, low overprotection) with one of their parents, four of them with their mother. The theory that Trower et al. (1995) put forward suggested that a child who had had a lack of

care and in addition an over-controlling parent, might fail to develop any sense of who they were, and have an *alienated self.* This data might lead one to suggest that for people to have an *alienated self,* lack of care alone could be sufficient, and that the only difference between those people who have a dependent kind of depression and those who have a self-critical one, might be the level of neglect alone. Although Drayton et al.'s (1997) study did find that parents of people fitting a 'bad me' kind of profile (although not explicitly suffering from persecutory delusions) did have affectionless controlling parents, this need not exclude the possibility that a 'bad me' profile could be obtained with neglectful parent alone. One problem with the idea that degree of neglect alone could make the difference between a self critical person and a dependent one is that this pattern of results would support the idea that greater neglect would lead to individuals having a self critical kind of depression, however, this would not sit very comfortably with data suggesting that disruptions in the attachment relationship occur earlier in the infants life (Blatt et al., 1979).

Problems with the PBI

On the whole then, responses on the PBI do not support the first hypothesis, although this assumes that this instrument is suitable for making the required distinctions. Murphy, Brewin & Silka (1997) in their re-factorisation of the PBI, noted that the factor they called encouragement of behavioural freedom was most predictive of future depression, rather than restriction of psychological autonomy. However, the relationship between dependency and self-criticism (and therefore 'poor me' and 'bad me' paranoia) had not been framed by Trower et al. (1995) in terms of this third variable, only in relation to a two-factor model. What the PBI does not do, as its originators concede (Parker et al, 1987), is to measure variations in parental care giving. So for example someone who had had disruptions to their care-giving in their first two years, but subsequently had had unremarkable parenting, might not record their parents as low in care. Or someone who had had low care in their early years, but affectionate constraining parenting thereafter, might report high care. Such people

are nevertheless, thought to store this information as emotional schemata (Leventhal, 1984) or as pre-verbal constructs (Kelly, 1955).

The other possible source of confusion in attempting to summarise an individual's parenting experiences is the notion of *multiple models* of self-representation (e.g. Bowlby 1973). These develop as a consequence of incompatible information from the social environment occurring at the same time in a child's life e.g. when an uncaring mother tells her child that she loves him. This might explain why for example a person gave a relatively benign account of their parenting – if the relevant mental representation of the parent was not activated. Power and Champion (1986) suggest that people with depression may have embedded self-models that are not available to conscious awareness unless a critical event occurs which triggers that model.

What other motives, conscious or unconscious, may determine inaccurate reports of parenting experiences? One of the primary emotions thought to play a role in 'bad me' paranoia is shame (Trower et al., 1995) and one of their supposedly primary defenses is to present a *false self* (Trower et al., 1995). It is therefore possible that such individuals, rather than giving a veridical account of their parent's behaviour towards them, gave what they perceived to be a socially desirable version of their experiences. This underlines the need for a measure of social desirability to be included in future studies, as Juusti-Butler (2000) has suggested, or to use a measure of automatic, parallel processes such as a Stroop test, which are not vulnerable to the effects of social desirability.

Myers, Brewin & Winter (1999) found that repressive coping was positively associated with higher care and lower overprotection from fathers on the PBI, however, when interviewed they appeared more similar to the 'low anxiety' group. If the 'poor me' group, use a repressive style then perhaps PBI ratings for this group ought to be viewed with caution.

Finally, there is the issue of paranoia and its effects upon disclosure of potentially sensitive information that could be used against them. The direct effect of paranoia upon scores on the PBI have not been performed before. However, Kinderman et al. (2000) who asked people with persecutory delusions to give descriptors for how their parents would describe them, found that this group tended to ascribe more negative views than a depressed control group. Similarly, Drayton et al. (1998) found that people with schizophrenia who endorsed negative self-self evaluations on the EBS rated themselves as low on maternal care. This would support the use of the PBI for this study to assess parental attitudes and behaviours.

Partly out of concern for the reliability and validity of PBI scores in this study, a reliability check was carried out (see table 3.0). Correlations between grid ratings for each parent with each sub-scale score on the PBI were calculated. All the correlation were in the expected direction although these were non-significant for the 'bad me' group on overprotection for both parents, and maternal care and paternal overprotection were relatively weak correlations for the 'poor me' group. In the case of the 'poor me' group, this may have been because they over-rated their mothers on the grid measure, on average giving their mothers 9.4 out of 13 (or '+2.4'). The 'bad me' group rated their mothers on average 9.1 out of 13 (or '+2.1). The mean number of negatively rated constructs for mother for the 'poor me' group was similarly lower at 2.9 than the 'bad me' group at 3.8. The PBI has also been used in other studies with mentally disordered participants, and although not explicitly stated probably included people with persecutory delusions (e.g. Helgeland & Torgersen, 1997).

Personal construct systems and paranoia

Similarity between the two types of paranoia and two types of perceptual defense based upon comparison of structural measures

Distance between self and social self

It was thought that the 'poor me' group would resemble people who used denial as a coping strategy (Catina et al., 1992; Dozier et al., 1995). On the basis of current findings it would seem that the tendency of the 'poor me' group to construe the elements *self* and *social self* in a relatively similar way when compared to the 'bad me' group, supported the idea that they might have been using a repressive or dismissive coping style. It also would tend to contradict Kinderman et al's (2000) contention that the use of this externalising negative other-self feedback would result in the social self being viewed very differently from the self e.g. "s/he hates me." What Kinderman et al.'s (2000) analysis does not consider is how such an evaluation is in itself evaluated or construed. Such an evaluation could be evaluated in terms of "people tend to hate me," or "most people like me, but this person hates me," i.e. global or specific. The reason that the 'bad me' group may have construed their social selves similarly to themselves, might go back to Trower et al. (1995). Specifically their original formulation of the problem for the 'bad me' paranoid was that they are attempting to prevent the self being constituted by the other i.e. it would be very difficult for such a person to say "they think I am X, but really I am Y." The case study of Janet, the person with a 'bad me' type of paranoia, was perhaps illustrative of such a process, given the high percentage agreement for construal of these elements.

The fact that 'poor me' group did construe the *social self* less complexly than the 'bad me' group again supports of the idea that constriction is used to deal with threat from others. This lends indirect support to the possibility that people with a 'poor me' type of paranoia have a

repressive style of coping or that the outcome of making external attributions for negative events reflects "a tendency to consider that the self-construction need not be revised because it matches the information conveyed by social feedback," (Catina et al., 1992). This is a strategy used by people who scored high on denial on the Questionnaire for Defensive Categories (SBAK; Ehlers & Peter, 1989).

Looking at paranoia as a dimensional trait in terms of levels of conviction for endorsement of paranoid attributions, the results are mixed. Based on the 'poor me' scale, the results supported the position taken by Kinderman et al. (2000) and Bentall et al. (1994), that social self and self would be perceived as being more dissimilar for people who made external, person attributions. For the 'bad me' continuum, the higher the conviction levels for 'bad me' attributions the less similar the construal of self and social self which also confounds the earlier finding. Of course each of these analyses is contaminated by the other sub-scale due to the fact that four of the participants were classified as having high levels of conviction for both types of paranoid attribution.

As has been noted, people identified as sensitisers were more likely to endorse negative traits for themselves or admit to psychopathology. It was interesting to see that the six people identified as 'bad me' (based on their delusional themes) were all rated as high on either the 'poor me' or 'bad me' scales, and for one person, both scales, perhaps reflecting this trait. Five of the 'poor me' group were not rated as having high conviction on either of the scales of the PSQ. However, three of those identified as 'poor me' (based upon their delusional themes) also endorse both types of paranoid attribution at the higher levels of conviction. This could either be due to a response bias that was independent of the type of paranoia as was mentioned above, or confirmation of sensitising and repressing styles for people with 'bad me' and 'poor me' paranoia respectively. However, in support of the idea of a response bias, the pattern of results based on PSQ scores consistently showed the tendency for more similar construing of the elements self with social self and self with ideal self, for people

who fell into the 'not poor me' and 'not bad me' groups. A third explanatory variable may be responsible for this pattern of results such as differences in intelligence levels (Chetwynd, 1977) which have been found to be associated with levels of cognitive complexity.

Tightness of construct systems

When tightness of construing was examined, little difference was found between the two groups based on content of delusions, although the 'poor me' group did have slightly tighter grids on average. This lends some tentative support to the idea that the 'poor me' group may tend to use a repressive style of coping (Catina, 1992), but is far from conclusive, and may equally suggest that the 'bad me' group also use a repressive style of coping. Perhaps this is likely to be the case, given that the Repression-Sensitisation scale reflects a continuum of response patterns (Byrne, 1963) that possibly have their origin in attachment experiences in childhood.

One possibility as to why there were negligible differences between tightness of construct systems for the two groups of paranoia (using either classification) could be the way in which different attachment strategies affect tightness and looseness of construing. However, Dozier et al. (1995) found that people identified as having a dismissive coping style (similar to repression) were identified from their responses on the Adult Attachment Interview (AAI) as having a loose thinking. There is a conceptual leap from loose thinking to loose construing, but it is not far. Also, a link between repressive and dismissive styles has not been established, although there is a striking resemblance between the two. Dozier et al's (1995) finding appears to directly contradict the finding by Catina et al. (1992), and does not really explain the current findings.

Drayton, Birchwood & Trower (1997) suggested that people with a 'bad me' paranoia may use constriction as a way of coping with potential invalidation of their construct systems. On

the one hand, Dozier et al. (1995) talked about the problems a child has in learning about emotions if they are taught to suppress the expression of any negative emotion, and this could well start in infanthood. Drayton et al. (1998) suggested that people who have a greater tendency for negative self-evaluation use a sealing over style of recovery. Hence, such findings would offer more explanatory value for the current data set, suggesting that the 'bad me' group utilise repressive strategies almost as much as the 'poor me' group.

The choice then appears to be between the 'bad me' group having tight constructs or the 'poor me' group having loose thinking (because they are assumed to have a dismissive style of coping). There is however, some apparent inconsistency with the first proposition. People who are able to own up to negative self-evaluations, would be considered to be using a hyper-activating strategy, consistent with someone who had a preoccupied attachment style, whereas someone with a deactivating style or dismissive style, would probably not own up to negative feelings. Equally, there is inconsistency in the idea that people who have a dismissive attachment style have loose construct systems, given the similarity between this style and that of someone who uses repression. However, it is possible, as Carr & Post (1974) set out to demonstrate, that repression is more of a response set than a way of coping with threat.

The results for the PSQ are somewhat conflicting with those based upon content of delusions. If one extrapolated from these results one would conclude that the degree of conviction in 'poor me' attributions was not linked to repressive coping, but that greater conviction in 'bad me' attributions did indicate a repressive style of coping. The alternative to the latter position is that the higher the conviction in 'bad me' attributions, the more likely that person would be depressed. Tight construing has been found to be indirectly associated with negative self-evaluation in its association with depression (Silverman, 1977; Sheehan, 1981). The first of these studies found that depressed people construed emotional constructs more tightly, perhaps indicating that such individuals have impoverished learning

experiences for emotional situations (Dozier et al., 1995). Sheehan's (1981) study looked at depressed people's construal of others' construal of themselves and found this to be tighter than a normal control group. Therefore, the slightly tighter construal of the 'bad me' group in this study, may reflect the fact that they do indeed resemble a depressed group, as has found to be the case in their responses on the EBS (Chadwick et al, 1997). To complicate matters, sensitisers have been found to more readily endorse negative self-evaluations (e.g. Byrne, 1961). Therefore, given that people with 'bad me' paranoia are generally more depressed, it is possible, as Byrne et al. (1963) found that they use sensitising strategies as well as strategies of denial.

Cognitive complexity

The 'poor me' group (based on either classification) did not have cognitively simpler grids, as would be expected if they tended to use repression as a defense. However, the greater relative complexity of self to other elements for people who fell into the 'poor me' group based on PSQ scores, does suggest that a tendency to make external attributions might result in the need for the self concept in general to be more meaningful. Meaningful is meant in a special sense here as allowing greater more discriminations can be made within the self-concept.

Use of emotional constructs

Due to the finding that the 'bad me' group endorsed more negative self-self evaluations on the EBS (Chadwick & Trower, 1996), and the greater tendency of people identified as using a sensitising defense to use emotional words (Byrne, 1961), the 'bad me' group were thought to resemble sensitisers. There was a clear trend towards the 'bad me' group using a greater number of constructs identified as 'emotional' by two independent raters which was approaching significance. This was all the more noteworthy given the observation that all

the participants in the 'bad me' group had been rated as in the top half for the 'poor me' and/or 'bad me' subscales.

Tightness of construing of self and other elements

Results here tended to confound the expectation that the 'poor me' group would have relatively tighter construal of their self elements, for both classification methods, even though neither difference was statistically significant.

Paranoia, self-esteem and repression-sensitisation

Contrary to expectations neither 'poor me' group had higher self-esteem based on similarity of construal of self and ideal self elements. However, the 'bad me' group showed a much larger range of self-esteem and the bulk of the 'bad me' results were visibly lower indicating less agreement on construal of these two elements, or lower self-esteem.

People in both the groups appeared to have quite high self-esteem based on this measure, the percentage agreement for both groups being in the high seventies. As mentioned earlier, there may have been considerable differential sampling biases due to the fact that people with a 'bad me' kind of paranoia who were more pre-occupied with their delusional beliefs, and therefore more distressed, might have been unwilling to engage in the study. Whereas the 'poor me' group despite greater pre-occupation, are not necessarily as distressed due to the self-esteem maintenance function of their delusions. Blatt et al. (1992) also note that "self-critical individuals are at a higher developmental level and therefore responsive to a wide range of experiences – to issues of loss as well as failure." This might account for the much broader range of discrepancies (see fig 1.1).

When examining the difference in the same measure based on PSQ categorisation, greater levels of conviction in both 'poor me' and 'bad me' appear to be very weakly associated with lower self-esteem. This makes sense if one considers that both kinds of paranoid attributions serve to protect self-esteem and that the more threatened a person's self esteem is, the more vigorously they may endorse such attributions. This finding was supported by the study be Chadwick et al (1997) which found that even the 'poor me' group endorsed negative self-self evaluations on the EBS. If this were the case, then recourse to such defensive strategies would appear to bring diminishing returns, in a similar way that levels of physiological arousal can maximise performance at optimal levels but inhibit it at higher levels. Such a pattern of results could also be produced by the same sampling error mentioned earlier.

In so far as differences in self-esteem were concerned, the results appear to be puzzling in that people who reported their mothers as more caring had lower self-esteem. Could this be a manifestation of guilt perhaps? Kelly conceptualises guilt as the feeling that one is not playing the role one ought to be. Perhaps their 'ought selves' to use Higgin's phraseology would correlate highly with their selves as their mother would like them to be? This could easily be assessed using grid measures. The other surprising result was that the high scorers on the 'poor me' subscale had lower self-esteem than the low scorers on the same scale, which appears to contradict many recent findings about an exaggerated self-serving bias operating in paranoia of the 'poor me' type. The alternative explanation is that responses on the PSQ are strongly effected by one or more personality variables e.g. repression. Lets say that repression was a strong feature of people with a 'poor me' type of paranoia, this would lead them to under endorse distressing statements that may be schema-activating (such as the statements on the 'poor me' PSQ scale). The consequences might be that people with greater concern with attachment and interpersonal issues would be more greatly repressed about such endorsements. Independent rating of repression and sensitisation for future research would be recommended on this basis.

On the whole then, the results in support of the 'poor me' group utilising repressive coping strategies are at best speculative. However, the non-significant trends towards this group having tighter grids than the poor me group, smaller distance between self and social self elements and the almost significant finding that, this group did not use as many emotional constructs as the 'bad me' group. Additional evidence is suggested by the generally lower conviction ratings on the PSQ (five 'poor me' people were rated as neither 'poor me' nor 'bad me' on this measure) for the 'poor me' group. In support of the idea that the 'bad me' group had a more sensitising approach to threat, there was a significant trend towards high scores on the 'bad me' PSQ scale to use more emotional constructs.

Weaknesses of study

The most obvious problem for this study was the low statistical power due to the small sample size, especially for the 'bad me' group, which made any conclusions, at best tentative. However, the data has thrown up some interesting questions, which could serve as a springboard for further research in this area.

PBI is unlikely to detect stage effects e.g. neglect at a particular time in life. Although respondents have been found to reliably fill in the PBI based on comparison with interviews about parenting experiences, the Blatt et al's (1992) theory of anaclitic or dependent kind of depression suggests that the relevant parenting experiences may not necessarily be available to conscious awareness. Nevertheless, according to both Personal Construct Psychology (PCP) and Leventhal's (1984) idea of emotional schemata, this information is likely to be stored in memory at a pre-verbal level (Kelly, 1955 cited in Winter, 1992, p.9)

The element composition in this study had fewer self-elements than other elements, a future study would utilise grids with the same number of elements for self and other, so that a within-participants comparison could be made. The reason for this, is that although

normative information for structural measures for grids has been published, this is perhaps to make the unjust assumption that the rating scales have equal and regular intervals between participants and that an identical summary figure has a similar meaning for each person.

The problem with this hypothesis was the conceptual jump that was made from the self described in Trower et al.'s (1995) paper, and the *self* as a self-consciously construed element in a repertory grid test. An extreme position might be to argue that all the elements of the grid are in a sense, self-representations (internal objects). Essentially, this is about whether the repertory grid is a valid tool for assessing hypotheses developed from within another theoretical framework. In a sense, the grid was used as a nomothetic tool in making the link between the grid structures of the two types of paranoia and comparing them with the grid structures of repressors and sensitisers. However, Watson & Winter (1999) note the unfortunate absence of normative data for grid measures. Also no independent measure of psychological defensive style was used which would have significantly

A problem for this study was that the element social self was a quite vaguely defined as "how other people tend to see me". More meaningful information might have been gathered by asking how specifically threatening people perceived them. This might be particularly relevant given that schematic activation would only occur in the presence of schematically relevant stimuli (Kroll & Deutsch, 1992), especially if the person had a dismissive attachment style or repressive coping style. Even then, this would not necessarily guarantee that such a person would give responses that reflected this schematic organisation, given that Dozier et al. (1995) found that people who had a dismissive attachment style tended to under-report their symptoms, which was in stark contrast to expert ratings of the level of psychopathology.

No measure was taken of social desirability which is one of the response errors for any kind of questionnaire method, however Chetwynd (1977) commented that this varies depending

on the elements included in the grid and the context in which it is administered. However, it was considered to be a defensive strategy of the person with 'bad me' paranoia that they might present a socially desirable version of themselves.

Cognitive complexity has been found to be associated with a multitude of variables (Chetwynd, 1977), and therefore, attempting to control for all of these other influence - e.g. levels of intelligence – would have made this project untenable. It might have been better to administer a measure of defensive styles such as the repression-sensitisation scale (Byrne, 1961) in order to determine if the two types of paranoia used different defensive styles. Nevertheless, the use of the grid enabled this study to ask the open-ended question of how the two groups might differ in their constructions of their interpersonal world.

Measures of delusional intensity (pre-occupation and conviction) along with levels of distress would have been useful in determining the level of schematic activation, which may be important (Garety et al., 2000) in determining whether or not a person's construct system is in a state of constriction. Constriction of a construct system might only occur if there is a perception of threat. An event is more threatening if it forces a change in the construct system which implies in self construction (Winter, 1992). Therefore, the very variable that this study was measuring could have been reduced in some participants given the sampling biases discussed earlier in the chapter. However, as mentioned earlier, levels of pre-occupation, conviction or distress were not expected to effect PBI scores. Additionally, it would be interesting to see how conviction and pre-occupation levels moderate levels of depression.

Although the current trend is for a symptom-based approach to understanding psychotic experiences, this perhaps ignores the multi-determined nature of them (Hingley, 1992). It is quite likely that delusions have a biological component to their causation which would not necessarily be controlled for simply be excluding those people with formal thought disorder.

For example, people with auditory hallucinations were not excluded, and this information was not systematically collected. The researcher was aware for example, that participants five to seven in table 1, had all been on neuroleptic medication for a very long time, and could be considered to be chronically mentally ill. Their delusions were of a more bizarre or more diffuse nature, but nevertheless met inclusion criteria for this study.

The construct elicitation method was not kept constant, and different elicitation methods have been shown to effect grid structures. Methods of difference such as the triadic elicitation method used in this study, have been found to produce "significantly higher levels of construct differentiation, lower numbers of positive emergent construct poles, and less socially undesirable implicit construct poles than "opposite" methods," (Hagans, Neimeyer & Goodholm, 2000). There were a few occasions when participants found it difficult to understand the triadic difference method, so the researcher resorted to asking for a construct with the opposite meaning.

Finally, there are the usual problems of correlation studies in that they are unable to say more than that there was an association between variables, without implying causation.

Finally, the established link between anaclitic depression and low care scores on the PBI on the one hand, and introjective depression and low care, high overprotection scores on the other hand, have not been firmly established. Therefore, it is difficult to interpret the non-significant findings as a falsification of the first research question.

Scientific Implications

The possibility that both groups of paranoia engage in different strategies makes assessment of the relevant construct systems or cognitive schemata problematic. For example, use of the dismissive attachment style by either group (Dozier, 1995), or presentation of a false self by the 'bad me' group (Trower et al, 1995), would suggest that alternative assessment methods

be explored. This would enable a fuller investigation into whether the two groups are differentially concerned with dependency and self-definition. On the basis of the findings in this study, there would seem to be quite a strong case for moving away from thinking about differences in traits, to thinking more about propensities towards different states.

Higgins (1999) proposes a model which is reminiscent of other cognitive schematic models of emotional processing such as the Johnson-Laird (1983) model, or the idea of cognitive-emotional schemata proposed by Levanthal (1984) in his idea of self-discrepancies. He conceptualised these as combinations of prototypes of selves, each one combined with an awareness of current self (state self). For example, what he calls *actual/own*, and *actual/other* represent the core sense of self and resemble the *subjective self* and the *objective self* that Trower et al. (1995) describe. He too thinks that people have multiple discrepancies and that a particular self-discrepancy would be recruited into conscious awareness due to a number of factors. These being: how recently that self-discrepancy was activated in the past – the idea of *priming* of constructs (Higgins, Jones and Rholes, 1977), and how meaningful the stimuli presented is to the particular construct or self-discrepancy; and whether that construct has been primed. Discrepancies are produced by a conflict between proto-selves e.g. *actual/own* and state selves e.g. *ideal/own* or *ought/other*. He proposes that different discrepancies have their own set of associated emotions. If Trower et al.'s (1995) model held, then Higgins' theory would predict that 'poor me' s would have an *ideal/own-ought/other* self-discrepancy because this would fit in with them being unjustifiably persecuted and feeling angry. Whereas the 'bad me' person might have an *actual/own-ideal/own* self-discrepancy producing feelings of worthlessness and failure.

Higgins et al. (1999) make a potential link between type of parenting and the kind of discrepancies a person has e.g. *actual/ought* may have a critical and punishing parent. Given that the defense (and hence the change in structure of construing – which might only be activated by the defensive mode) would according to Higgins only be activated when

relevant stimuli are presented, assessments of self-discrepancies would have to take this into account.

This paper recognises that the concepts of dependency and self-criticism as themes in parenting may be less important than *who* is doing the parenting and *when* because of the lack of clear differences in the two groups. Indeed mixed evidence has been found for this specificity in depression (e.g. McCranie and Bass, 1984). Blatt et al. (1992) argue that dependent depressives would find it hard to give a critical account of their parents due to fears of loosing that attachment, and they also cite the issue of the early stage in life when dependency issues are played out. However, there is no reason why this latter point should obstruct identification of this subgroup, if indeed it exists.

Based on the finding that 'bad me' females reported on average lower maternal care, and that 'poor me' males did not report as much low maternal care as the 'bad me' group, this study proposes that the critical determinant of the formation of a fragile sense of self (self-schema) as found in 'bad me' paranoia, would be the lack of maternal care in the first two to five years (Blatt et al., 1992). This is further supported by the Drayton et al. (1998) study that found that high negative self-evaluators reported lower levels of care. Furthermore, the finding that the 'bad me' group spontaneously generated more interpersonal themes, and assuming that these constructs represent ones which are more easily available to consciousness, and therefore, genuinely reflect the preoccupations of the individual, it might tentatively be suggested that it is the 'bad me' group who are preoccupied with dependency issues. This does not mean that the 'poor me' group are not preoccupied with dependency, just that they deal with it in a different way. The two separate ways are analogous to the reactions of the insecurely attached child in the Strange Situation (Ainsworth, Blehar, Waters & Wall, 1978) i.e. more about process than content. It could be thought of as the 'bad me' exhibiting anxious attachment and the 'poor me' as exhibiting an avoidant attachment style,

although these are no longer behaviours, because the 'bad me' avoids others, rather they are attitudes to others.

Clinical Implications

Therapeutic relationship

What is uncontroversial from the current findings is that people with either kind of paranoia are likely to have had less than optimal parenting experiences as children. The majority may well report lack of care. It is entirely possible that the precise experiences may not be accessible to conscious awareness because of the stage at which ruptures in the parent-child relationship occurred. In keeping with Levanthal's (1984) idea of schematic activation, it is possible that an innocent remark, a smell or a noise could activate a particular set of schemata that affect the therapeutic relationship. So as Brewin (1988) warns "that limitations on self-reports mean that attention must be paid to regularities in behaviour and speech, contexts in which inappropriate feelings and behaviour occur, and indirect cues to underlying emotional states." For example, in case study 1 (chapter 3), John would quite often get irritated by his therapist, in keeping with a dismissive coping style, but would claim that he was completely non-violent. Dozier suggested that people who have a dismissive attachment style have been rated as more hostile than either preoccupied or secure individuals (Kobak & Sceery, 1983). It is again perhaps more than a coincidence that Trower et al. (1995) described the affective profile for the person with 'poor me' paranoia, as including anger and hostility.

Dozier et al. (1995) suggested that people with a dismissive attachment style are a challenge to therapists in that they tend to elicit unhelpful responses from others, including therapists (Dozier, 1992). Therapists who also have a dismissive attachment style may find working with such people difficult due to their inability to detect distress in this type of client, as

opposed to a client who has a preoccupied style (Dozier et al., 1994). If the current study's tentative links between 'poor me' paranoia and a repressive style of coping are valid, then it is likely that there may be similar kinds of counter-transference occurring for therapists who see people with 'poor me' paranoia, as there might be for therapist who see people who have a dismissive attachment style.

It is worth noting the subtle conceptual difference between perceptual defense and attachment styles. Bowlby (1980, pp. 52-53) suggested that all perceptual information gets filtered by a principal, hierarchical system or systems which scan the information in a matter of fractions of seconds, and that much of this gets rejected as redundant. This is the level at which Bowlby considered perceptual defense to operate. Patterns of attachment on the other hand are considered to be much higher up the hierarchical system and are algorithms that have been developed due to repeated learning experiences. Both processes are automatic, but only the latter process can be brought into conscious awareness, although Bowlby speculated that it may be possible to even access information screened out by the first filter by using hypnosis. It is these patterns of attachment that are played out in the therapeutic relationship. The task of therapy then, is to bring into conscious awareness these interactional patterns that occur between client and therapist. Trower et al. (1995) suggest that one of the tasks for therapy is the reconstruction of the self, which is achieved through learning in the therapeutic relationship, but also addressed explicitly when assumptions and evaluative beliefs about the self and others are addressed in cognitive therapy. These authors go on to cite Davidson & Strauss (1992) who suggest the need for clients to be less the passive recipients of treatment, and more actively the collaborative participants in their own recovery and development, which ought to contribute to developing a positive sense of self, with strong self-efficacy.

Trower et al. (1995) note that a person with 'poor me' paranoia will either attempt to secure the therapist's attachment by getting them on their side and perhaps seeing them as some

kind of saviour, or view the therapist as a persecutory figure. They recommend that the therapist avoids either position, but instead offer a secure relationship. The task for therapy, they suggest, is to fundamentally address the negative self-evaluative beliefs that perhaps underpin their fears of abandonment. If however, the 'poor me' group were more likely to use a repressive kind of coping, this is likely to effect how well the therapist can address the full range of evidence that may support or disconfirm the negative self-evaluative beliefs. For example, in case study 1, reported in Chapter 3, John had rated himself as zero on the constructs ill, sad, insecure and disorganised. A rating of zero either means that the person is saying that that construct does not apply to them, or it can also be interpreted as indicating the *submergence* (i.e. unconscious construing only occurs) of that construct. These zero ratings on constructs may well represent the operation of a repressive perceptual-defensive style for constructs which are a threat to the defensive construction of the paranoid self. This could be useful information for the therapist in terms of forewarning them of the potential flashpoints in therapy e.g. it might not be particularly helpful in terms of engaging John in the early stages of therapy to talk about illness models, as is suggested by some approaches to cognitive therapy for delusions. Indeed, his therapist informed the researcher that this had been a particularly sensitive issue to broach, and John had avoided hospitals for many years before the admission that had brought him into contact with services.

For a person with 'bad me' paranoia, the main challenge for engagement may be getting them to come to therapy at all, because such individuals expect to be taken over, controlled or denigrated. Trower et al. (1995) suggest the therapeutic task for this group is to undermine the negative self-evaluation and the belief in the other's omniscience (e.g. that their evaluations are always right). The person in case study 2, (Chapter 3) was perhaps demonstrating progress in her therapy in that some of the 'other' elements were negatively rated.

Much of the relevant emotional material may well be buried (as borne out in the comparison of the 'bad me' group to Drayton et al.'s (1998) sealing over group), or not easily divulged, not least because one of the dominant schemata is likely to be regarding trust, and the expectation that this would be used as evidence by the therapist to dominate and control them. Treatment of the 'bad me' group would probably involve a slow development of the therapeutic relationship, perhaps one which allows a re-modelling of a caring relationship for the person.

Consistent with the idea that it is the 'bad me' group who are perhaps more fragile, it is not unreasonable to suppose that one defensive strategy they have is to close down and constrict their construct systems. Trower et al. (1995) highlighted the need for unconditional, positive regard, in conjunction with gentle reflection and mirroring, whilst slowly and carefully challenging the client's negative beliefs about self and others with the goal of working towards a re-construction of the self. The value of Socratic questioning which does not impose answers or suggestions would be particularly appropriate given the fear that the person with 'bad me' paranoia fears being taken over and controlled.

Jones & Pittman's (1982) paper on self-presentational strategies is a useful conceptual framework for thinking about strategies that a person with paranoia might use to avoid engaging with their emotional difficulties, this being thought to be the central defensive function of paranoia. He lists a number of conditions in which self-presentational strategies may be short-circuited, these being: complete involvement in a task, pure emotional expression, indulging in over-learned or ritualised behaviours and being involved in situations where people might be motivated to behave authentically e.g. therapy situation. These suggestions converge with those of Dozier et al. (1995) that people with dismissive attachment styles, and Myers et al. (1999) that people identified as repressors, when in an interview situation, find it much more difficult to divert the attention away from the painful

issues. However, given the above cautions, such techniques one could only imagine using much later on in the therapy.

Another potential issue is that those people with dismissive attachment styles also tend to push social support away and are likely to wait until crisis before they seek help. The description of the person with 'bad me' paranoia is very reminiscent of a child who is anxious – avoidant (Bowlby, 1980) and who would be described as using a dismissive coping style. It would make sense therefore, in terms of a stress-vulnerability model, to perhaps include an educational approach for the person with 'bad me' paranoia, which focussed on their propensity to behave in this way, with practical suggestions on how they could feel comfortable seeking help before a crisis occurs. The challenge may be more than one of communication, in that the client may not recognise their own signs of distress at first. There is an apparent contradiction between the 'bad me' group having a dismissive attachment style on the one hand and a sensitising approach to threat, which warrants further investigation.

Assessment

If the perceptual defensive style of people with 'poor me' paranoia is repressive, then it is highly likely that using the verbal information alone from the clinical interview may not be entirely helpful. The repertory grid technique, may therefore, serve as a good way of systemically identifying the potentially central negative self-evaluative beliefs that Trower et al. (1995) think are so critical to making progress in therapy. So, as mentioned earlier, in case study 1 (Chapter 3) John's ratings of zero on the constructs 'well-ill', 'secure-insecure', 'happy-sad' and 'organised-disorganised' may well be a clue what these beliefs are for John. There is a tension in cognitive therapeutic approaches to the emphasis given in assessment, to experiences in childhood (Chadwick et al., 1996), however, given the potentially powerful experience for a person with 'poor me' paranoia having a therapist listen to their childhood

experiences and not reject or abandon them, could be a very useful learning experience for them. Perhaps getting the client to complete a repertory grid before childhood data is collected, may be a good way of identifying areas to focus on in the assessment of their childhood, and also areas to avoid in the earlier stages of treatment. Trower et al (1995) suggest focussing on identifying the desired self, the type of threat the person is defending against, and the type of defense they are using as part of the assessment process.

On a more positive note, due to the fact that people have access to multiple representations of self, they are likely to have access to a healthier functioning version which could perhaps be accessed by asking them about times when they *were* cared for by somebody.

Suggestions for further research

Firstly, it is worth mentioning the context of further research with this particular client group. These particular methods would be best used within a trusting therapeutic relationship that the paranoid person had. This kind of research could well be carried out on an ongoing basis, the repertory grid interview being a good introduction in the personal construct system of the paranoid person. It is hoped that within this context, it may feel safer for the paranoid person to explore with the therapist their anxieties and concerns and perhaps give permission to explore painful areas in the way that has been suggested in the scientific implications section (about activating the appropriate schemata).

Two further aspects follow on from this study. Firstly, verification of tightness of construing around clusters of constructs for the self and secondly, verification of parental specificity.

With a view to the former, it is probably worth taking on board ideas from both cognitive psychology and personal construct theory. This is the idea that constructs have to be elicited using the right cues (cognitively speaking) or with the elements that are likely to be within

the range of convenience for the particular problem being addressed (Kelly, 1955, p.68). Therefore, because of the findings of Sheehan (1981) that depressed people are concerned with interpersonal themes, and because both groups may be differentiated with the degree to which they are concerned with interpersonal themes, it would be useful to use elements that are constructs of another's construal of the individual e.g. "how would your mother describe you?" Furthermore, it may be useful to use elements that represent good functioning for them in their lives, as a within-subjects control for tightness and looseness of construing.

Related to the issue of choosing appropriately targeted elements, it might be worth asking the person to describe some ought standards as constructs perhaps asking "How would your parents describe the person that you ought to be". This would activate the relevant representations (self-discrepancies) constructs or schemata that are relevant to their vulnerabilities (of the self being taken over and controlled by the other). This is the concept of priming schemata and could be achieved in any number of ways. Of course the appropriate ethical considerations would apply to any such research, and participants would have to be debriefed, however, as mentioned earlier, research within a therapeutic setting using single-case series would be the ideal option.

There is also the problem of stages of development as being potentially crucial in the development of one kind of paranoia or another, specifically the possibility that 'bad me's may present a false self. This lends support to the idea of using assessment tools that look at automatic and parallel processes, rather than serial, conscious thought processes to assess the way in which parents are represented. An example quoted in Blatt et al. (1992) is of subliminal messages and their effect upon depressive symptoms (e.g. Silverman & Weinberger, 1985)

If the two types of paranoia are defenses against the two types of depression, then exposure to interpersonal loss and personal failure may be found to cause relatively larger amounts of

distress in 'poor me' and 'bad me' paranoia respectively. The problem with using analogue stimuli such as the DEQ or even exposure to subliminal messages with these themes, is that the 'poor me' group – and possibly the 'bad me' group – probably tend to utilise a dismissive coping style, associated with denial and low acknowledgement of personal distress, despite signs to the contrary. Therefore, it would probably be important to access memories and stories that are personally relevant in order to first activate the relevant self-schemata, and then to use a physiological measure to determine distress. People with dismissive styles have been found to have physiological reactivity to stressful situations in spite of not acknowledging the difficulty they are in (Dozier et al., 1994). There are ethical problems with such a study, and it would best be carried out within the context of a therapeutic relationship under completely transparent circumstances

Conclusions

This was a study to establish whether the concepts of 'poor me' and 'bad me' were making a useful clinical distinction, and one that made sense of the theoretical links proposed by Trower and Chadwick to exist between early attachment experiences. On the basis of similarities between the defensive styles of people with 'poor me' paranoia and repressors on the one hand, and people with 'bad me' paranoia and sensitisers on the other, its second aim was to explore the links between the personal construct systems of these respective groups.

It was hypothesised that people with both types of paranoia would have low care scores on the PBI and in addition that the 'bad me' group would high overprotection scores on the same measure. Findings supported the first part of this prediction in that the majority of participants reported low levels of care. The second part of this prediction was not confirmed, in fact based upon group data, the 'bad me' group reported marginally less overprotective fathers. In addition, the range of scores on maternal overprotection for the 'poor me' group was twice that of the 'bad me' group. The 'bad me' group reported lower

maternal care, whereas the 'poor me' group reported lower paternal care. Explanations for these findings were explored, and included the possibility of contamination through sampling biases, response biases of participants (repressor or sensitiser), small sample size and arguments whether the links between the two kinds of depression and the two different patterns of parenting experiences could be justified.

Repressors have been found to have tighter grids, and have less complex grids, and construe their self and social self elements more similarly than people who use a sensitising style of coping with threat. On the basis that the 'poor me' defensive style resembled that of a repressor, and the 'bad me' resemble a sensitiser (because of their readiness to endorse negative self descriptions) it was expected for the two groups of paranoia to demonstrate similar differences in their grids. Trends in the data tended to support this comparison, although the only statistically significant finding on construal of the self and social self, was found not to hold when thought disorder people were excluded from the analysis. These findings warrant further investigation with a larger sample size and perhaps within a single diagnosis such as Delusional Disorder.

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APPENDICES

I. Patient information sheet for consultants

II. Letters of ethical approval

III. Patient information sheet for participants

IV. Mill Hill Vocabulary Scale

V. Fransella & Bannister Grid Test of Schizophrenic Thought Disorder

VI. Scoring for Intensity and Consistency

VII. Plausible Scenarios Questionnaire

VIII. Parental Bonding Instrument

IX. Patient consent form

Camden and Islington NHS
Mental Health NHS Trust

PSYCHOLOGICAL ASSESSMENT AND TREATMENT SERVICE
THE PSYCHOLOGY DEPARTMENT
Charterhouse building, Archway Campus
Highgate Hill, London. N19 3UA
Tel: (020) 7530 2350 Fax: (020 7530 2370

Dear

I am writing to inform you of the research that I am continuing to carry out within the Trust. Additionally, I am hoping that you may be able to assist in identifying suitable participants and/or raising this at one of your team meetings.

Earlier this year I was carrying out research for my doctorate in clinical psychology within Camden and Islington, having obtained the necessary ethical approval from the local research ethics committee. However, I fell short of the required number of people required for my study and I am now seeking to recruit participants again.

The study is looking at differences in thinking styles and attachment styles between people with 'poor me' paranoia (persecutory paranoia) and 'bad me' paranoia (punishment paranoia).

I enclose an outline of the study. Please note, that I am able to pay participants £10 to cover their expenses.

As you can see, the procedure was rather a long and involved one for people with these particular presenting problems, so I am also keen to recruit people to just fill in the Parental Bonding Instrument. This will not necessarily require any contact with myself, although I would advise contact workers to supervise the completion of these which take between 10 and 20 minutes to complete. Unfortunately, I cannot pay people for doing this.

The contact for this study within the Trust is Steve Pilling. I can be contacted at chris.keeley@cichs-tr.nthames.nhs.uk or on my mobile phone:.

Yours sincerely

Chris Keeley

Clinical Psychologist in Training

SELF REPRESENTATION AND ITS DEVELOPMENTAL ORIGINS IN TWO TYPES OF PARANOIA

Research Procedure

Participants will be recruited through Consultant Psychiatrists in the Barnet area. Consultants will do this by telling prospective participants about the project and giving them a printed information sheet about the study. If people show an interest in participating, they will be given the opportunity to ask further questions of the researcher, Chris Keeley.

Once people have had the opportunity to ask questions, they will be invited to meet with Chris Keeley at a health clinic or psychiatric unit, convenient to the participant. In some circumstances, home visits will be considered, when considered appropriate by the Consultant Psychiatrist.

Having gained formal consent, participants will carry out the following:

- *Mill Hill Vocabulary Scale*

- *Franscella and Bannister Grid Test of Schizophrenic Thought Disorder*

- *This is a test designed to screen out those participants who have formal thought disorder and consists of a number of photographs of peoples' faces, which are rated on various attributes. For example, participants would be asked, "which person is the kindest person amongst these people," and this would be repeated until the faces are rank ordered for this attribute. This is done for six other attributes and then the whole procedure is repeated to obtain a reliability measure of participants' rankings.*

- *Thinking Styles Questionnaire (See attached)*

- *Parental Bonding Instrument (Parker, Tupling and Brown, 1979)*

This is used to sort the participants into 'poor me' and 'bad me' paranoia. See research proposal for details.

THE ABOVE WILL TAKE ABOUT AN HOUR.

Then, participants will be asked if they want to continue, have a break, or continue on another occasion. Once decided, the participant will then be taken through a semi-structured interview. This will involve presenting participants with a series of 'elements' these being:

A sad person; a happy person; self as I am; someone I dislike; someone I like; employer who I got along with; employer I didn't get along with; self as I expect to be in a year's time; self as I'd like to be; self as other people see me; partner (or someone I have loved); father; mother

The interview will take the following format: - three elements at a time will be presented to the participant, and they will be asked in what way two of the elements are alike and what way the third is different, or failing that, what the opposite is of the attribute they have chosen. This procedure will continue until fourteen bi-polar constructs have been elicited from participants. Finally, participants will rate each element on each of the fourteen bi-polar constructs that have been elicited on a bi-polar thirteen point scale going from –6 to +6 with zero in the middle.

THIS PROCEDURE WILL TAKE BETWEEN AN HOUR AND AN HOUR AND A HALF.

This will end the formal procedure, and participants will be invited to ask any questions they like about the procedure.

Due consideration will be given to participants' mental state during the procedure and if it is suspected that a participant is in distress, they will be asked if they want to stop or have a break. For individuals who have difficulty concentrating, more than one break will be offered anyway.

Barnet NHS
Health Authority

Hyde House
The Hyde
Edgware Road
London
NW9 6QQ

Tel: 0181 201 4700
Fax: 0181 201 4701

(From April 22nd 2000) Tel: 020 8201 4700
Fax: 020 8201 4701

17th December 1999

BARNET RESEARCH ETHICS COMMITTEE

Please quote protocol number on all correspondence

Mr. Christopher Keeley
33 Ritches Road
South Tottenham
London N15 3TB

Dear Mr. Keeley,

Ref: Study 99/70

Title: Self Representation and its developmental origins in two types of paranoia

Your study was discussed at the meeting of the Barnet Local Research Ethics Committee on 8th December 1999.

The study was approved subject to a satisfactory response to the following points:

a) The consultant psychiatrist needs to approach suitable patients **not** the investigator.

b) A consent form is required.

Yours sincerely,

Michael Beaman

Michael Beaman
Chairman

Camden and Islington NHS
Community Health Services NHS Trust

LOCAL RESEARCH ETHICS COMMITTEE

Research & Development Unit, 3rd Floor, West Wing, St. Pancras Conference Centre
St Pancras Hospital, London NWI OPE
tel: 020 7530 3376 fax: 020 7530 3235
email: research.office@dial.pipex.com
Chair: *Stephanie Ellis* Administrator: *Ayse Ali*

Thursday, 07 December 2000

Mr Christopher Keeley
33 Riches Road
South Tottenham
LONDON
N15 3TB

Dear Mr Keeley

LREC Ref: 00/104 (please quote in all further correspondence)
Title: Self representation and its developmental origins in two types of paranoia

Thank you for your correspondence dated 23 November 2000 with the revised patient information sheet and consent form. I am pleased to inform you on behalf of the Local Research Ethics Committee that the amendments are satisfactory and you have ethical approval to proceed with your study. Please would you write and inform **Angela Williams** of the start date of your project, at the above address.

Please note that the following conditions of approval apply:

- It is the responsibility of the investigators to ensure that all associated staff including nursing staff are informed of research projects and are told that they have the approval of the Ethics Committee.

- If data are to be stored on a computer in such a way as to make it possible to identify individuals then the project must be registered under the Data Protection Act 1998. Please consult your department data protection officer for advice.

- The Committee must receive immediate notification of any adverse or unforeseen circumstances arising out of the project.

- The Committee must receive notification: a) when the study is complete; b) if it fails to start or is abandoned; c) if the investigator/s change and d) if any amendments to the study are made.

Stephanie Ellis
Ethics Committee Chair

INFORMATION SHEET (Date: 13/04/00)

Study Title: How people who are referred to psychiatric services think about themselves and others.

Investigator: Christopher Keeley, Trainee Clinical Psychologist

INTRODUCTION

This study will look at how people who are referred to psychiatric services view themselves and other people. It also uses a short questionnaire to ascertain what kinds of parenting experiences people had. This is being done in order to see if there is a link between these experiences and how we view ourselves and others in later in life.

WHAT WILL BE REQUIRED OF YOU?

If you agree to take part in this study, you will be asked to fill in some questionnaires initially. Following that you may be invited in for an interview with Chris Keeley at a time convenient to you.

During this interview, you will be asked to think about the people you know, to think of words that describe them, and then to rate them on each of these qualities that you have chosen.

The whole procedure may last as long as two and a half hours, and although it is possible to do this in one sitting, there will always be the option of doing it over more than one occasion.

Any travel expenses will be refunded.

CONFIDENTIALITY

All the information that you give in both the questionnaires and interview will be kept solely by Chris Keeley alone who will always be the interviewer. The information will be written down, but your name will not appear on any of these records.

None of your doctors, nurses, social workers or other health professionals will have access to the information that you divulge as part of your participation in this study. Therefore, participation in this study will not affect any treatment you may be receiving.

LOOKING AFTER YOURSELF

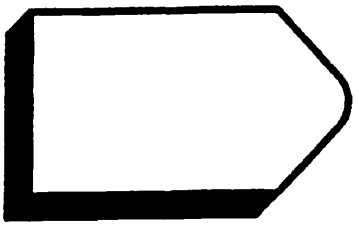
If for any reason you no longer wish to participate in the study, you are welcome to drop out at any point. Whilst you are not required to say why, the investigator would be grateful to know your reasons for doing so.

WHAT'S IN IT FOR YOU?

Some people find that the kind of interview being carried out here can provide a fascinating insight into what they are like as people. If people are interested, feedback based on the interview can be provided at a later date.

ANY OTHER QUESTIONS?

If you would like to find out more about this study before agreeing to participate, please contact Chris Keeley by leaving a message on **0181 732 6984**



RECORD FORM FOR THE MILL HILL VOCABULARY SCALE FORM 1 JUNIOR

(1988 Revision)

Throughout this answer sheet, please complete the information asked for next to any headings written in BROWN, and read and carry out all other instructions given in BROWN.

Name: Date:

Age: ..... years ..... months Date of Birth: ..... Sex: .....

Place of Testing: Name of Tester:

What is the name of your father's job? What exactly does he do in that job?

What is the name of your mother's job? What exactly does she do in that job?

DO NOT OPEN THIS ANSWER SHEET UNTIL YOU ARE ASKED TO DO SO

MHV

Open Ended Raw Score:	.....	Time Taken:	.....
Multiple Choice Raw Score:	.....	Time Taken:	.....
TOTAL MHV SCORE:	.....	TOTAL TIME TAKEN:	.....
Percentile: (refer to manual)	.....	Grade: (refer to manual)	.....

SPM

SPM Raw Score: Set A:	.....	TOTAL TIME TAKEN:	.....
SPM Raw Score: Set B:	.....		
SPM Raw Score: Set C:	.....	Percentile: (refer to manual)	.....
SPM Raw Score: Set D:	.....		
SPM Raw Score: Set E:	.....	Grade: (refer to manual)	.....
TOTAL SPM SCORE:	.....		

Prepared by J C Raven, J Raven and J H Court
Published by Oxford Psychologists Press Limited, Oxford, England (Product No: 2253)

SET A: OPEN ENDED

Write down in a few words, on the brown line, the meaning of each of the following words. If you don't know the meaning of a word, put a question mark and go on to the next one. The first one has been done for you as an example..

TIME STARTED:

1. Cap — A kind of hat
2. Loaf
3. Unhappy
4. Afraid
5. Near
6. View
7. Continue
8. Startle
9. Perfume
10. Ache
11. Rage
12. Squabble
13. Connect
14. Provide
15. Brag
16. Shrivel
17. Mingle
18. Stance
19. Verify
20. Formidable
21. Thrive
22. Docile
23. Virile
24. Surmount
25. Sultry
26. Criterion
27. Latent
28. Dwindle
29. Construe
30. Efface
31. Trumpery
32. Perpetrate
33. Glower

SET B: MULTIPLE CHOICE

In each group of six words below, carefully fill in in the brown lozenge ⬭ next to the word which is closest in meaning to the word in heavy type above the group. Make sure you fill in in one lozenge only. If you make a mistake, put a cross (✗) through the incorrect answer and fill in the correct one. If you don't know the answer, have a guess or move on to the next question. The first one has been done for you as an example. Work downwards through each column.

TIME STARTED:

1. Tomato

- ⬭ fly
- ⬭ wood
- ● fruit
- ⬭ crack
- ⬭ dunce
- ⬭ step

7. Battle

- ⬭ stroll
- ⬭ snow
- ⬭ bowl
- ⬭ light
- ⬭ fight
- ⬭ last

13. Liberty

- ⬭ freedom
- ⬭ rich
- ⬭ forest
- ⬭ worry
- ⬭ serviette
- ⬭ cheerful

. Toss

- ⬭ throw
- ⬭ hide
- ⬭ dive
- ⬭ catch
- ⬭ roll
- ⬭ pull

8. Patch

- ⬭ mend
- ⬭ hand
- ⬭ switch
- ⬭ watch
- ⬭ bang
- ⬭ cook

14. Stubborn

- ⬭ steady
- ⬭ obstinate
- ⬭ orderly
- ⬭ hopeful
- ⬭ hollow
- ⬭ slack

Damp

- ⬭ light
- ⬭ sweet
- ⬭ wet
- ⬭ bag
- ⬭ letter
- ⬭ flag

9. Disturb

- ⬭ transfer
- ⬭ lick
- ⬭ doubt
- ⬭ skip
- ⬭ upset
- ⬭ fire

15. Precise

- ⬭ natural
- ⬭ faulty
- ⬭ stupid
- ⬭ exact
- ⬭ grand
- ⬭ small

Rest

- ⬭ cry
- ⬭ go away
- ⬭ run up
- ⬭ sing
- ⬭ taste
- ⬭ lie down

10. Blaze

- ⬭ kitchen
- ⬭ grass
- ⬭ flare
- ⬭ coat
- ⬭ roof
- ⬭ side

16. Resemblance

- ⬭ memory
- ⬭ assemble
- ⬭ attendance
- ⬭ fondness
- ⬭ repose
- ⬭ likeness

Cruel

- ⬭ clean
- ⬭ pretty
- ⬭ water
- ⬭ green
- ⬭ found
- ⬭ unkind

11. Malaria

- ⬭ basement
- ⬭ theatre
- ⬭ ocean
- ⬭ fever
- ⬭ fruit
- ⬭ tune

17. Anonymous

- ⬭ applicable
- ⬭ insulting
- ⬭ nameless
- ⬭ magnificent
- ⬭ fictitious
- ⬭ untrue

Receive

- walk
- believe
- money
- ⬭ accept
- ⬭ empty
- ⬭ drive

12. Fascinated

- ⬭ ill-treated
- ⬭ poisoned
- ⬭ frightened
- ⬭ modelled
- ⬭ charmed
- ⬭ copied

18. Elevate

- ⬭ raise
- ⬭ revolve
- ⬭ waver
- ⬭ move
- ⬭ work
- ⬭ disperse

PLEASE TURN OVER

19. **Task**

- horn
- trap
- problem
- game
- jail
- job

24. **Conciliate**

- congregate
- pacify
- compress
- reverse
- radiate
- strengthen

29. **Bombastic**

- democratic
- bickering
- destructive
- anxious
- cautious
- pompous

20. **Courteous**

- dreadful
- polite
- curtsey
- proud
- short
- truthful

25. **Envisage**

- enfeeble
- surround
- activate
- contemplate
- estrange
- regress

30. **Levity**

- parsimony
- salutary
- alacrity
- frivolity
- velleity
- tariff

21. **Prosper**

- imagine
- succeed
- punish
- propose
- beseech
- trespass

26. **Amulet**

- cameo
- flirtation
- charm
- jacket
- crest
- savoury

31. **Whim**

- complain
- tonic
- wind
- noise
- fancy
- rush

22. **Lavish**

- unaccountable
- romantic
- extravagant
- selfish
- lawful
- praise

27. **Garrulous**

- talkative
- massive
- ridiculous
- daring
- ugly
- fast

32. **Ruse**

- limb
- trick
- colour
- paste
- burn
- rude

23. **Immerse**

- frequent
- reverse
- rise
- hug
- dip
- show

28. **Libertine**

- profligate
- farrago
- regicide
- rescuer
- canard
- missionary

33. **Recumbent**

- fugitive
- unwieldy
- penitent
- cumbersome
- repelling
- reclining

TIME FINISHED:

TOTAL SCORE FOR SET B:

GRID TEST OF SCHIZOPHRENIC THOUGHT DISORDER
MANUAL
INTRODUCTION

All forms of Repertory Grid technique are derivatives of an orig developed by G.A. Kelly (1955). In essence repertory grids are forms of sor tests. They differ from conventional sorting tests in that there is no si standard set of materials to be sorted nor sorting categories to be used; no there any standard single form of administration or scoring procedure. The esse of any grid test is that what is measured is the relationship between the sor categories (constructs, concepts, ideas) for the subject, not the "correctness' the sorts as such.

The assumption underlying all forms of repertory grid examination is the psychological relationship between any two constructs for a given subjec reflected in the statistical association between them when they are used sorting categories by the subject. This rationale can be exemplified in the extr case as follows. If the subject nominates 40 people known personally to him categorises each in turn as MORAL or NOT MORAL and then re-sorts them HONEST or NOT HONEST and we find that the 20 designated as MORAL also designated as HONEST and the 20 designated as NOT MORAL are designated as NOT HONEST, then we can infer a high positive relations (which can be measured in terms of its binomial probability) between the const MORAL – NOT MORAL and the construct HONEST – NOT HONEST for t subject. This Manual describes a particular standard form of grid test wh has been developed to detect the presence of schizophrenic thought disor However, this should not be taken to imply that this is either the only or primary use of grid tests as such. Examples of the diversity of form and purp of grid techniques within the clinical field can be found in Fransella and Ada (1965), Crisp (1964), Landfield and Nawas (1964), Sechrest (1962) and Banni (1965A).

Previous Work

In two previous studies (Bannister 1960 and 1962) thought disorde schizophrenics were discriminated from normals and other psychiatric gro (including non thought disordered schizophrenics) by forms of repertory grid te The primary characteristics of thought disordered schizophrenics, in terms such tests, appear to be their failure to manifest substantial intercorrelati between constructs and their inability to maintain in a second grid the speci pattern of intercorrelations found in the first. In Construct Theory terms (Ke 1955 and Bannister 1962A) schizophrenics are limited to an overly loose inconsistent subsystem for construing people, in conventional terms their id about people are both poorly related and unstable.

A previous report of this test was given in Bannister and Fransella (19

Test procedure

The test is designed for individual administration as follows:

1. Place in front of the subject the array of eight photographs.

2. Ask the subject to study these photographs and tell him that he will be asked questions about the people in them. Give the subject roughly half a minute to look at the photographs.

3. Ask the subject which of the people whose photographs he has examined is the most likely to be KIND. When the subject has made his selection turn this photograph face down and write the letter, which is printed on the back, on the Record Sheet against "1st" for KIND. Ask the subject to select the person most likely to be KIND from the seven remaining photographs. Turn this photograph face down and note its letter against "2nd" on the Record Sheet. Continue in this way until the subject has in effect ranked all eight photographs from the most KIND to the least KIND.

4. Turn all the photographs face upwards, shuffle them to change their desk positions and ask the subject to select the person most likely to be STUPID.

5. Turn his chosen photograph face down, note its letter and ask the subject to select the most STUPID from the remaining photographs. Proceed in this manner until the subject has in effect rank ordered the eight photographs for STUPID and you have noted down the order in which they were selected on the Record Sheet.

6. Proceed in this manner until the subject has rank ordered the eight photographs on the six constructs noted on the Record Sheet, i.e. KIND, STUPID, SELFISH, SINCERE, MEAN and HONEST.

7. Give the following further instructions to the subject: "Now that you are quite familiar with the procedure and the pictures, I should like you to do it all again. If you feel you want to change your mind you may, because this is not a memory test. There are no right or wrong answers; I just want to know how you feel about these people now that you have thought about them a lot".

8. Repeat the test procedure exactly as before entering the subject's rankings under Grid II on the Record Sheet.

9. If the subject asks what meaning he is to attach to words like KIND, STUPID and so forth, tell him to use the words in his own personal sense, i.e. to use KIND to mean whatever he would mean by it if in conversation he said someone was a kind person.

10. If the subject complains that the task is difficult, encourage him to do his best and tell him that this may mean in effect that he has to guess.

11. If the subject claims that for a particular quality there are no representatives, e.g. there are no really STUPID people in the group, tell him he is to select the one who comes nearest to being STUPID as compared with the others, even while it may be true that there are no really STUPID people in the sample.

12. The subject can pick up the photograph he has selected and hand it to the examiner or handle them generally if he wishes.

Scoring

Two scores, Intensity and Consistency, are derived from the test protocol. The scores are entered on to the Analysis Sheet as they are worked out.

The original rankings in the two test booklets must be rearranged a entered into the two rank order tables shown in the Analysis Sheet. The ra order tables on the analysis sheets are so arranged that the constructs l a are shown along the top, the elements (photographs) letters A to H are sho down the side and what is entered in the body of the table is the rank positi of the particular photograph on the particular construct. Thus if the subject s selected photograph F as first for K|ND then in the intersect of element F construct I the number 1 will be entered. Figure I below shows a set of origi rankings converted into a rank order table.

Figure I

Table of Original Rankings (From Record Sheet)

	Constructs →	1	2	3	4	5	6
Element Positions ↓	1st (most)	E	B	A	A	G	D
	2nd	F	C	G	G	A	G
	3rd	D	H	C	E	C	E
	4th	C	D	B	D	B	F
	5th	H	A	H	C	H	A
	6th	G	G	F	F	E	B
	7th	B	F	D	B	F	H
	8th (least)	A	E	E	H	D	C

Rank Order Table (From Analysis Sheet)

Elements ↓	1	2	3	4	5	6
A	8	5	1	1	2	5
B	7	1	4	7	4	6
C	4	2	3	5	3	8
D	3	4	7	4	8	1
E	1	8	8	3	6	3
F	2	7	6	6	7	4
G	6	6	2	2	1	2
H	5	3	5	8	5	7

Intensity

Before scoring instructions are given in detail for the intensity score, summary is given as follows. Spearman rank order correlations between a possible pairs of constructs on Grid I (the first administration) and all possib pairs on Grid II (the second administration) are worked out (15 rhos for ea grid) and squared and multiplied by 100 (retaining sign) to give "percenta variance in common" scores, (this latter procedure transforms correlations in a linear form suitable for use as scores). These thirty scores are total (disregarding sign) and this total is the intensity score for the subject. Hi scores indicate that the subject is rank ordering as if the qualities he is judgi are related (significantly correlated either negatively or positively) and lo scores indicate that he is treating them as relatively independent (correlational

Scoring:

1. Take each pair of constructs in turn beginning with constructs 1 and 2 as represented by columns 1 and 2 in the rank order table (Analysis Sheet). Square each of the differences between equivalent rank positions in the table and add these squares together. (Note that the largest possible difference is seven and therefore differences can be squared mentally and it is advisable to enter them one by one into a desk calculator or adding machine, if one is available, so as to arrive at the total of squares without having to write out the individual squares).
2. Look up this sum of the squared differences in Table 1 and find the equivalent **relationship score** (plus or minus) and enter this relationship score on the Analysis sheet next to the construct pair 1–2. For interest's sake the actual rho is also shown on the table.
3. Take the next pair of constructs i.e. 1–3 as represented by columns 1 and 3 and repeat the procedure of squaring the differences in ranks and looking up the sum of these squares in Table 1 and enter the equivalent relationship score as shown by the table on the analysis sheet next to 1–3.
4. In this way derive a relationship score for all possible pairs of constructs, that is 1–2, 1–3, 1–4, 1–5, 1–6, and 2–3, 2–4, 2–6 up to 5–6.
5. Repeat this procedure exactly for Grid 2.
6. Total the 15 grid relationship scores of Grid 1 (ignoring whether they are plus or minus). Total the relationship scores of Grid II in the same way. Add these two totals together and this final total constitutes the Intensity score for the subject.

Consistency

Before giving scoring instructions in detail a summary of scoring procedure is given as follows. The 15 relationship scores of Grid 1 are rank ordered from the highest positive through zero to the highest negative, and the relationship of Grid II treated in the same manner. The Spearman rank order correlation coefficient is calculated for these two sets of rankings. This rho is the Consistency score and reflects the degree to which the subject has maintained the pattern of relationships between these constructs from Grid 1 to Grid II and it is in effect a test re-test correlation. It is mathematically independent of the Intensity score which is concerned purely with the size of correlations whereas Consistency measures the degree to which the subject continues on retest to see the personal qualities named in the test as related in a particular fashion.

Scoring

1. On the analysis sheet you will see that next to the column in which the relationship scores are entered is the heading "Rank of relationship scores". Examine the relationship scores of Grid 1 and find the highest plus score. Next to this in that column write 1 to indicate that it is ranked highest. Find the next highest plus relationship score and enter 2 next to it. Carry on until all plus relationship scores are exhausted then rank

rank this next. Proceed with the ranking until the final rank of 15 given to the highest minus relationship score.

2. If you find two or more relationship scores which are the same, th them tied ranks by allotting the central rank to them in the conve manner, (e.g. if rank positions 9 and 10 are occupied by two equal s they both receive the rank of 9.5).

3. Rank order the relationship scores of Grid II in the same way, giving to the highest positive and working down through zero so that the r goes to the highest negative relationship score.

4. Now calculate the Spearman rho coefficient of correlation between t sets of rankings of relationship scores which have just been con for Grid I and Grid II. That is to say the difference between each ranks is squared and the sum of these squared differences totalle rho is then found according to Spearman formula as follows:

$$\text{Spearman rho} = 1 - \frac{6 \text{ Sum } d^2}{n^3 - n}$$

or for fifteen entries this is in effect

$$\text{Spearman rho} = 1 - \frac{\text{Sum } d^2}{560}$$

5. This rho is the subject's Consistency score.

Example

In Table II an example test protocol is fully scored. It is suggeste you apply the scoring instructions yourself to the example and compare th scores you obtain in order to check whether you are scoring in exactly the prescribed.

Age, Sex and Intelligence

Age Intercorrelations of age with Intensity and Consistency scores fo of the various groups tested as a normative population are shown in Table II

Organics appear as an exceptional group in that within this popu both Intensity and Consistency correlate significantly and negatively witl In investigating the genesis of this relationship it was found that ag significantly related to type of brain damage in the organic group. With sample, diffuse brain damaged and/or post-operative patients were olde localised brain damage and/or pre-operative patients (chi square $p < .0$ turn it was found that the two types of brain damage were linked to differ test scores. The diffuse brain damage and post-operative group have signifi lower intensity scores ($p<.01$) and consistency scores ($p<.02$) than the loc damaged pre-operative group. This may well underlie the age-test scores corre for the organic group. However, for non-organic populations there is no indicat

ID TEST
NNISTER-FRANSELLA)

N _____ _____ _____

Date _____

ANALYSIS SHEET

RANK ORDER TABLES COMPILED FROM RECORD SHEET

GRID I

CONSTRUCTS

ELEMENTS	1	2	3	4	5	6
A						
B						
C						
D						
E						
F						
G						
H						

GRID II

CONSTRUCTS

ELEMENTS	1	2	3	4	5	6
A						
B						
C						
D						
E						
F						
G						
H						

istruct airs	Relationship Score	Rank of Relationship Scores	Construct Pairs	Relationship Score	Rank of Relationship Scores
–2			1–2		
–3			1–3		
–4			1–4		
–5			1–5		
–6			1–6		
–3			2–3		
–4			2–4		
–5			2–5		
–6			2–6		
–4			3–4		
–5			3–5		
–6			3–6		
–5			4–5		
–6			4–6		
–6			5–6		

Total :

Total :

INTENSITY SCORE (GRAND TOTAL) = _____

TABLE VIII

INTENSITY

CONSISTENCY	400	500	600	700	800	900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400
1.0	0	1	4	8	15	22	25	37	53	60	66	77	86	89	93	95	97	98	98	98	100
.9	0	1	4	8	15	21	25	36	51	57	64	74	82	84	86	87	88	89	89	89	91
.8	0	1	4	8	15	18	21	28	39	43	46	49	54	54	56	56	57	58	58	58	58
.7	0	1	3	7	12	15	15	19	26	28	29	33	35	35	35	35	36	36	36	36	36
.6	0	1	2	6	10	11	11	13	19	20	20	21	21	21	21	21	21	22	22	22	22
.5	0	1	1	5	7	8	8	8	12	13	13	13	13	13	13	13	13	14	14	14	14
.4	0	1	1	5	5	6	6	6	8	8	8	8	8	8	8	8	8	8	8	8	8
.3	0	1	1	5	5	5	5	5	7	7	7	7	7	7	7	7	7	7	7	7	7
.2	0	0	0	3	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
.1	0	0	0	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
0	0	0	0	0	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
−.1	0	0	0	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
−.2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
−.3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
−.4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
−.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

NON-THOUGHT DISORDERED SUBJECTS, (NORMALS, NEUROTICS, DEPRESSIVES, NON-THOUGHT DISORDERED SCHIZOPHRENICS) Percentage of non-thought disordered subjects below each pair of readings.

Appendix VII Plausible Scenarios Questionnaire

This is a questionnaire investigating people's thinking styles. You will be presented with descriptions of ten situations and six possible explanations for these situations. Please try to imagine yourself in each situation and rate each of the following explanations in terms of how much you believe it to be true on the scale (1 = definitely not true; 10 = definitely true). Please rate all of the explanations. Finally, please circle how many times this situation has happened to you. A space is provided after each situation for you to make any comments that you feel would be helpful.

Thank you for your time and attention.

1. You are walking along a pavement by the side of the road and it is raining heavily. There are large puddles of water in the gutter which extend into the road. A car comes by close to the kerb and splashes water over you.

What is the most likely reason for this?

☐ A) The car has been forced to pass close to the kerb (e.g. because of traffic coming the other way), and so you have been unfortunately and unavoidably splashed.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ B) The driver splashed you deliberately.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ C) The driver should have been more careful in driving under such conditions and realised that pedestrians could get splashed by water thrown up by the wheels.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ D) You should have walked further away from the kerb.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ E) The driver splashed you deliberately which is the kind of thing you deserve.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ F) The driver splashed you deliberately, which was totally unjustified.

Belief: 1 2 3 4 5 6 7 8 9 10

How many times have you been in this situation? 0 1-2 3-4 5+

3. You are walking down a crowded street when someone you feel you know fairly well passes you without acknowledging you or even indicating that he / she recognises you.

What is the most likely reason for this?

☐ A) The other person had his/her mind on other things and therefore was not paying proper attention to who passed by.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ B) You might have mistaken a stranger for somebody that you know.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ C) The other person did not want to recognise you and so chose to ignore you.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ D) The other person deliberately ignored you, and that was totally unjustified.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ E) The other person was unable to spot you in the heavy crowd.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ F) The other person deliberately ignored you, which is the kind of thing you deserve.

Belief: 1 2 3 4 5 6 7 8 9 10

How many times have you been in this situation? 0 1 - 2 3 - 4 5 +

5. You are travelling by bus and want to get off at the next stop. You get up in good time and ring the bell to indicate to the driver that you want to get off. The bus goes on past the stop and takes you further than you want to go.

What is the most likely reason for this?

☐ A) The driver would have stopped for you but just did not hear the signal.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ B) The driver actually did not want to stop at that particular place to let you off, which was totally unjustified.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ C) You might not have pressed the bell properly and so the driver could not have heard it.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ D) The driver actually did not want to stop at that particular place to let you off.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ E) The driver had his/her mind on other things and was not concentrating as well as he/she should have done.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ F) The driver actually did not want to stop at that particular place to let you off, which is the kind of thing you deserve.

Belief: 1 2 3 4 5 6 7 8 9 10

How many times have you been in this situation? 0 1 - 2 3 - 4 5 +

7. You ask an official at a railway station about travelling to a particular place. Although taking note of what you think that he/she said you arrive at the station too late to catch the right train.

What is the most likely reason for this

❑ A) The official was actually trying to mislead you, which is the kind of thing you deserve.

Belief: 1 2 3 4 5 6 7 8 9 10

❑ B) The official did not do his/her job properly by taking careful enough note of what you were asking and so ended up by giving the wrong information.

Belief: 1 2 3 4 5 6 7 8 9 10

❑ C) You may have failed to make clear to the official just what information you wanted or may have misunderstood what you were told.

Belief: 1 2 3 4 5 6 7 8 9 10

❑ D) The official was actually trying to mislead you.

Belief: 1 2 3 4 5 6 7 8 9 10

❑ E) The official may have simply misunderstood you and so given wrong information in error.

Belief: 1 2 3 4 5 6 7 8 9 10

❑ F) The official was actually trying to mislead you, which was totally unjustified.

Belief: 1 2 3 4 5 6 7 8 9 10

How many times have you been in this situation? 0 1 - 2 3 - 4 5 +

9. You have a meal in a canteen or restaurant. Some hours later you start to feel ill and have quite a bad stomach upset. It appears that your illness is a consequence of something that you ate.

☐ A) The staff deliberately tried to cause you to suffer food poisoning.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ B) There is always a risk of food poisoning. No matter how good hygiene is in food preparation, it is impossible to totally prevent this sort of thing happening.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ C) The staff deliberately tried to cause you food poisoning, which is the kind of thing you deserve.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ D) You should have been paying more attention to the condition of the food before eating it.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ E) The staff deliberately tried to cause you food poisoning , which was totally unjustified.

Belief: 1 2 3 4 5 6 7 8 9 10

☐ F) The staff did not pay enough attention to the food preparation.

Belief: 1 2 3 4 5 6 7 8 9 10

How many times have you been in this situation? 0 1 - 2 3 - 4 5 +

Appendix VIII Parental Bonding Instrument

PBI

This questionnaire lists various attitudes and behaviours of parents. As you remember your own MOTHER in your first 16 years would you place a tick in the most appropriate box next to each question.

EXAMPLE:

		Very like	Moderately like	Moderately unlike	Very unlike
9.	Tried to control everything I did	[ ]	[ ]	[ ]	[✓]

		Very like	Moderately like	Moderately unlike	Very unlike
1.	Spoke to me with a warm and friendly voice	[ ]	[ ]	[ ]	[ ]
2.	Did not help me as much as I needed	[ ]	[ ]	[ ]	[ ]
3.	Let me do things I liked doing	[ ]	[ ]	[ ]	[ ]
4.	Seemed emotionally cold to me	[ ]	[ ]	[ ]	[ ]
5.	Appeared to understand my problems and worries	[ ]	[ ]	[ ]	[ ]
6.	Was affectionate to me	[ ]	[ ]	[ ]	[ ]
7.	Liked me to make my own decisions	[ ]	[ ]	[ ]	[ ]
8.	Did not want me to grow up	[ ]	[ ]	[ ]	[ ]
9.	Tried to control everything I did	[ ]	[ ]	[ ]	[ ]
10.	Invaded my privacy	[ ]	[ ]	[ ]	[ ]
11.	Enjoyed talking things over with me	[ ]	[ ]	[ ]	[ ]
12.	Frequently smiled at me	[ ]	[ ]	[ ]	[ ]
13.	Tended to baby me	[ ]	[ ]	[ ]	[ ]
14.	Did not seem to understand what I needed or wanted	[ ]	[ ]	[ ]	[ ]
15.	Let me decide things for myself	[ ]	[ ]	[ ]	[ ]
16.	Made me feel I wasn't wanted	[ ]	[ ]	[ ]	[ ]
17.	Could make me feel better when I was upset	[ ]	[ ]	[ ]	[ ]
18.	Did not talk with me very much	[ ]	[ ]	[ ]	[ ]
19.	Tried to make me dependent on her	[ ]	[ ]	[ ]	[ ]
20.	Felt I could not look after myself unless she was around	[ ]	[ ]	[ ]	[ ]
21.	Gave me as much freedom as I wanted	[ ]	[ ]	[ ]	[ ]
22.	Let me go out as often as I wanted	[ ]	[ ]	[ ]	[ ]
23.	Was overprotective of me	[ ]	[ ]	[ ]	[ ]
24.	Did not praise me	[ ]	[ ]	[ ]	[ ]
25.	Let me dress in any way I please	[ ]	[ ]	[ ]	[ ]

PBI

This questionnaire lists various attitudes and behaviours of parents. As you remember your own FATHER in your first 16 years would you place a tick in the most appropriate box next to each question.

		Very like	Moderately like	Moderately unlike	Very unlike
1.	Spoke to me with a warm and friendly voice	[ ]	[ ]	[ ]	[ ]
2.	Did not help me as much as I needed	[ ]	[ ]	[ ]	[ ]
3.	Let me do things I liked doing	[ ]	[ ]	[ ]	[ ]
4.	Seemed emotionally cold to me	[ ]	[ ]	[ ]	[ ]
5.	Appeared to understand my problems and worries	[ ]	[ ]	[ ]	[ ]
6.	Was affectionate to me	[ ]	[ ]	[ ]	[ ]
7.	Liked me to make my own decisions	[ ]	[ ]	[ ]	[ ]
8.	Did not want me to grow up	[ ]	[ ]	[ ]	[ ]
9.	Tried to control everything I did	[ ]	[ ]	[ ]	[ ]
10.	Invaded my privacy	[ ]	[ ]	[ ]	[ ]
11.	Enjoyed talking things over with me	[ ]	[ ]	[ ]	[ ]
12.	Frequently smiled at me	[ ]	[ ]	[ ]	[ ]
13.	Tended to baby me	[ ]	[ ]	[ ]	[ ]
14.	Did not seem to understand what I needed or wanted	[ ]	[ ]	[ ]	[ ]
15.	Let me decide things for myself	[ ]	[ ]	[ ]	[ ]
16.	Made me feel I wasn't wanted	[ ]	[ ]	[ ]	[ ]
17.	Could make me feel better when I was upset	[ ]	[ ]	[ ]	[ ]
18.	Did not talk with me very much	[ ]	[ ]	[ ]	[ ]
19.	Tried to make me dependent on him	[ ]	[ ]	[ ]	[ ]
20.	Felt I could not look after myself unless he was around	[ ]	[ ]	[ ]	[ ]
21.	Gave me as much freedom as I wanted	[ ]	[ ]	[ ]	[ ]
22.	Let me go out as often as I wanted	[ ]	[ ]	[ ]	[ ]
23.	Was overprotective of me	[ ]	[ ]	[ ]	[ ]
24.	Did not praise me	[ ]	[ ]	[ ]	[ ]
25.	Let me dress in any way I please	[ ]	[ ]	[ ]	[ ]

Barnet Community Healthcare NHS
NHS Trust

Centre Number:
Study Number: 99/70
Patient Identification Number for this trial:

CONSENT FORM

Title of Project: How people who are referred to psychiatric services think about themselves and others.

Name or Researcher: Christopher Keeley

Please initial box

1. **I confirm that I have read and understand the information sheet dated 13/04/00 for the above study and have had the opportunity to ask questions** ☐

2. **I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected** ☐

3. **I understand that sections of any of my medical notes may be looked at by Chris Keeley or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records.** ☐

4. **I agree to take part in the above study** ☐

Name of patient	**Date**	**Signature**
Name of Person taking consent (if different from researcher)	**Date**	**Signature**
Researcher	**Date**	**Signature**

1 for patient; 1 for researcher; 1 to be kept with hospital notes