Early Relationships and Emotional Experience in Two Types of Paranoia

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Abstract

Using a cross sectional group comparison design, this study tested theoretical predictions arising from the distinction between two types of persecutory delusions: ‘Poor Me’ and ‘Bad Me’ paranoia. Specifically, Trower and Chadwick (1995) propose that the two types can be related to early experience of relationships and vulnerability to different types of threat to self-construction.

Participants currently experiencing persecutory delusions were reliably categorised as Bad Me or Poor Me by the researcher and a blind rater. A battery of self-report measures, which focused on the constructs hypothesised to differ between the two groups, was then administered and the responses of each group compared.

Several theoretical predictions based on Trower and Chadwick’s (1995) model were supported by the study. Namely, the Bad Me group was found to report early relationships with caregivers characterised by greater over-intrusion than the Poor Me group, and the Bad Me group also reported more shame and depression than the Poor Me group. However, the hypotheses that the Poor Me group would report early relationships characterised by neglect, and that each group would report greater vulnerability to different types of threat to self-construction were not supported.

The findings suggest that persecutory delusions, which superficially appear to be similar in nature, may in fact reflect different experiences of early relationships and different psychological profiles.
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Chapter One
Introduction

Traditionally, ‘persecutory delusions’ have been thought of as a single sub-category of delusional beliefs. However, Trower and Chadwick (1995) made an interesting theoretical distinction between two types of persecutory delusions: ‘Poor Me’ paranoia, where the individual believes persecution to be unfair and unjustified, and ‘Bad Me’ paranoia, where the individual believes themselves to be in some way deserving of persecution. Trower and Chadwick (1995) offer distinct cognitive developmental formulations for these two types of paranoia, based on experience of early relationships, and related core interpersonal rules and beliefs, which influence “the person’s current emotional, cognitive and behavioural experience” (Chadwick, Trower, Juusti-Butler & Maguire, in press, p. 4).

To date there has been little research that examines the theoretical predictions that arise from their model. This study, therefore, aims to test specific theoretical predictions arising from the distinction between Bad Me and Poor Me paranoia.

The first section of this chapter examines the symptom-based approach to research. Following this, the challenge of defining persecutory delusions is considered, and the criteria used in the present study are set out. It is argued that delusions lie on a continuum with normal beliefs, and therefore can be influenced by existing core beliefs about the self, the world and others.
The next section outlines evidence that suggests a predominance of negative core self-beliefs amongst individuals experiencing persecutory delusions. This is important, as Trower and Chadwick's (1995) theory makes a distinction between the two types of paranoia in terms of self-schema thought to arise through different types of early relationships.

The next section focuses on theories of persecutory delusions. Research examining the theory that persecutory delusions serve as a defence against depression is addressed, and different interpretations of the inconsistent findings in this area are considered.

In the final section, Trower and Chadwick's (1995) theory of two types of paranoia is examined in detail, with a focus on the theorised origin of the two types in terms of self-construction and early relationships. Differences in the current experience of shame and depression between the two types that would be predicted based on this theory is also outlined. Following this, the present study is described and the hypotheses are presented.

Research investigating the process of delusion formation and maintenance is assimilated in a recent and comprehensive review by Bentall, Corcoran, Howard, Blackwood and Kinderman (2001). They distinguish between two distinct, but not mutually exclusive, lines of investigation. One line of research focuses on the perceptual, attentional and reasoning processes amongst those with delusions, and identifies ways in which these processes may lead those with delusions to
make inaccurate judgements about external events (see Garety & Hemsley, 1997). The other focuses specifically on persecutory delusions, and how these might reflect a motivated attempt to defend against negative beliefs about the self. This line of exploration is closely linked with the current study, and will be thought about in detail through this chapter. However, it is important to bear in mind that research along both lines is important and can be combined to inform our understanding of the formation and maintenance of delusions.

**A symptom-based approach**

There is a considerable amount of research focusing on persecutory delusions relative to other types of delusions. Reasons for this include their relatively common appearance amongst psychiatric patients (Garety, Everitt & Hemsley, 1988; Jorgensen & Jensen 1994, cited in Bentall et al. 2001), because they are associated with more distress than some other types of delusions, such as grandiose delusions, and because they are more likely to be acted upon than other types of delusions (Wessely et al., 1993). In addition, research on persecutory delusions has a long and established history, catching the imagination of the early psychoanalysts (Freud, 1911/1950).

Much of the research into persecutory delusions has focused upon the phenomena independently, rather than as part of a specific syndrome. This symptom-based approach has several advantages. Firstly, delusions are present in a wide variety of disorders, including neurobiological, physiological and psychiatric conditions (Garety & Hemsley, 1997). Though usually considered
central to the diagnosis of schizophrenia, they can occur in all the psychotic conditions, including bi-polar and schizo-affective disorder, and in the affective disorders, primarily depression. There is debate questioning the reliability and validity of diagnosis of different psychotic disorders, particularly between schizophrenia and the affective disorders (Bentall, Jackson & Pilgrim, 1988; Kendell & Brockington 1980). It is therefore clear that much information would be lost if researchers only considered persecutory delusions associated with a specific diagnosis and that by considering persecutory delusions as a symptom, rather than as part of a diagnostic cluster, misclassification of participants can be avoided. Persons (1986) makes this point as part of an argument for the study of particular symptoms, such as hallucinations, delusions and thought disorder, rather than syndromes. She also proposes that a symptom-based approach allows the facilitation of theoretical development, recognition of the continuity of clinical phenomena with normal phenomena, and improvements in diagnostic classification.

Defining persecutory delusions

An operational definition

The most common method of categorising delusions is by content (Maher, 1988). Attempts have been made to identify sub-types of delusions based on themes, including the theme of persecution. However, Freeman and Garety (2000) highlight the multidimensional nature of persecutory delusions. They stress the need for researchers to be looking at the same phenomena when
considering the differences between factors responsible for the formation, maintenance and appraisal of delusions, and have proposed operational criteria for classifying a delusion as persecutory:

**Criteria A and B must be met.**
A. The individual believes that harm is occurring, or is going to occur, to him or her self.
B. The individual believes the persecutor has the intention to harm.

**There are a number of points of clarification:**
I. Harm concerns any action that leads to the individual experiencing distress.
II. Harm to only friends and relatives does not count as a persecutory belief, unless the persecutor also intends to have a negative affect upon the individual.
III. The individual must believe that the persecutor at present or in the future will attempt to harm him or her.
IV. Delusions of reference do not count in the category of persecutory beliefs.

(from Freeman & Garety, 2000, p. 412).

Bentall et al. (2001) suggest that it is difficult to distinguish between persecutory delusions and delusions of sin or guilt, where the individual believes that they have committed some offence so that persecution is deserved. They argue that delusions of sin and guilt are more common amongst those with a primary diagnosis of depression, and suggest adding to Freeman and Garety's (2000) definition that the intended harm should be out of all proportion to offences committed by the person in the past, in an attempt to distinguish between persecutory delusions and delusional guilt. However, it is argued here that these sub-types of delusions are not mutually exclusive: that some people experiencing persecutory delusions also believe themselves to be deserving of this persecution and that this group represent an important sub-group within persecutory
delusions, and would be excluded from research using Bentall’s et al.’s (2001) extended definition. This argument is in line with Trower and Chadwick’s (1995) distinction between Bad Me and Poor Me paranoia, which will be discussed in more detail later.

It is also argued that the delusional belief that an individual deserves persecution is not restricted to cases where the primary diagnosis is one of depression.

Indeed, Chadwick et al. (in press) have conducted research using a sample of participants who believed themselves to be deserving of persecution, comparing this group with those who did not. In their sample of 53 participants there was only one case of psychotic depression in each group. All other participants had a primary diagnosis of schizo-affective disorder or paranoid schizophrenia.

*Delusional beliefs on a continuum with normal beliefs*

Early and largely unsuccessful attempts to define delusions, and distinguish between these and ‘normal’ beliefs, focused on identifying qualitative differences (for example Jaspers, 1913/1963). Such definitions often viewed delusions as ‘ego-dystonic’, and diagnosis focused on the form of delusions, for example whether they were held with utter conviction and impervious to counter-argument, rather than their content (beyond whether or not the belief was considered ‘impossible’).

However, more recent research has indicated similarities between delusional and normal beliefs. Evidence suggests that delusions, like normal beliefs, vary in
terms of degree of conviction (e.g. Harrow, Rattenbury & Stoll, 1988), and that they may be firmly held, but are not completely resistant to modification, or insensitive to reason (Chadwick & Lowe, 1990; Chadwick et al. 1994). Moor and Tucker (1979) note that false beliefs are common in the normal population, and thus falsity per se is not a substantial criteria for defining delusions. Furthermore, it has been argued that 'bizarreness', which has previously been used to identify delusional thinking, is difficult to rate as it varies widely across different cultures, groups and periods of history (Harper, 1992).

Concordant with this argument, in more recent years there has been a shift away from qualitative towards quantitative definitions of delusions. This approach locates delusional beliefs along a continuum with normality, the position on this continuum being influenced by variables such as degree of belief conviction and the extent of pre-occupation with the belief (Strauss, 1969). The view that delusions lie on the same dimension as normal beliefs is supported by findings that delusional type thinking can be found amongst the general population who have not come into contact with psychiatric services (for example Peters, Joseph & Garety, 1999; van Os, Hanssen, Bijil & Ravelli, 2000), and is reflected by attempts to identify criteria that allows beliefs to be considered as 'more or less delusional' rather than present or absent (for example see Oltmanns, 1988). Indeed, the DSM-IV definition of a delusion recognises that 'delusional conviction occurs on a continuum and can sometimes be inferred by an individual's behaviour. It is difficult to distinguish between a delusion and an over-valued idea (in which case the individual has an unreasonable belief or idea
but does not hold it as firmly as is the case with a delusion' (American Psychiatric Association [APA], 1994, p765).

In summary, research supports the case for placing delusions on a continuum with normal beliefs. In terms of cognitive theory (Beck, 1967), this carries with it the assumption that delusional beliefs, like normal beliefs, can be influenced by core beliefs about the self, the world and others. Such beliefs are thought to be established through early experience, particularly of relationships with caregivers (Beck, 1967; Young 1994).

Attempts have been made to understand the relationship between core beliefs and the content of persecutory delusions. For example, Freeman, Garety, Kuipers, Fowler and Bebbington (2002) propose a cognitive model of the formation and maintenance of persecutory delusions, applying Garety, Kuipers, Fowler, Freeman and Bebbington's (2001) model of the positive symptoms of psychosis. Leading up to delusion formation, individuals are searching for explanations of internal anomalous experiences (Maher, 1988), recent external events, or arousal. In the search for meaning core beliefs about the self, others and the world related to current emotional state, are drawn upon. They claim that a persecutory belief is more likely to be formed and strongly held if consistent with existing firmly held distorted beliefs, for example that the individual is vulnerable, or that they deserve to be harmed, or because they view other people and the world as hostile and threatening on the basis of early experiences, such as trauma (Freeman et al. 2002). Thus, the delusion is consistent with existing beliefs about the self, others and the world.
This section has presented the operational criteria that will be used by the current study to identify individuals experiencing persecutory delusions. It is argued that it is important to include participants who experience delusions of sin and guilt in research, if they are also experiencing persecutory delusions as defined by the operational criteria. The theory that delusions lie on a continuum with normal beliefs has been presented. This theory carries with it the assumption that the content of delusions can be influenced by core beliefs about the self, which are assumed to be formed largely through early experience, particularly of relationships (Beck, 1976; Young, 1994). Finally, a model which proposes a link between core beliefs and delusional content was described (Freeman et al, 2002). The next section will address research examining the type of core beliefs held by individuals with persecutory delusions. Such research is limited, as until recently this has been a largely neglected area of study.

**Negative core beliefs and delusions**

There has been some research linking negative early experience such as poor attachment relationships, and negative internalised belief systems, especially regarding self-evaluation, with vulnerability to psychotic symptoms. For example, Garety et al. (2001) suggest that earlier adverse experiences or unsupportive family environments contribute to the development of negative schemas, which may create enduring cognitive vulnerability to psychotic symptoms characterised by negative schematic models of the self, the world and others that facilitate external attribution and low self esteem.
Birchwood, Meaden, Trower, Gilbert and Plaistow (2000), in developing a model of auditory hallucinations, propose that whether or not a voice is believed to be ‘malevolent’ or ‘benevolent’ is influenced by core interpersonal cognitive schemata which are believed to represent the individual’s past and current experience of interpersonal relationships, particularly powerful care-givers. They suggest that a childhood experience of social adversity, for example critical comments from powerful care-givers, leads to the development of negative schemas involving social humiliation and subordination, which in turn fuel voices and paranoia.

Some research has identified an association between negative core beliefs and delusions. For example, delusional disorder patients have been found to score highly on the Dysfunctional Attitude Scale (DAS), which measures attitudes that delineate excessively rigid, perfectionist criteria for evaluating self worth (Fear et al., 1996). This finding was replicated by Bentall and Kaney (1996) in both depressed paranoid and non-depressed paranoid patients.

Bentall and Swarbrick (2001) used the Personal Style Inventory (Robins et al., 1994) to examine two types of negative self-schema identified by Beck (1983): ‘sociotropy’ (evaluating self-worth in terms of love and approval by others) and ‘autonomy’ (evaluating self-worth in terms of achievements and ability to control one’s destiny). They predicted that patients whose persecutory delusions had remitted would tend to be pre-occupied about the attitudes that others held towards them, and would therefore score high on ‘sociotropy’, whereas currently
deluded patients would tend to be rejecting of others and would therefore score highly on autonomy. Initially their results supported their predictions. However, when depression was included as a covariate, differences in ‘sociotropy’ largely disappeared, and differences in autonomy completely disappeared.

In summary, there is some evidence to suggest that people with persecutory delusions have negative core beliefs, and it has been suggested that the nature of these beliefs may influence a person’s experience of persecutory delusions. However, as yet there has been little attention paid to the nature of early relationships that might be linked to development of these beliefs (Beck, 1967, Young, 1994), and how these things combined may influence the type of paranoia and emotions experienced by the individual.

**Persecutory delusions as a defence against depression**

Bentall, Kinderman and Kaney (1994) drew a parallel between the latent negative self-beliefs observed amongst those with persecutory delusions and those with depression. They argue that, in the case of depression, when negative self-representations are primed by threatening events leading to discrepancies between the actual and ideal self (Higgins, 1987), these negative self-representations become active and are experienced by the depressed person. However, in the case of persecutory delusions, external (other blaming) attributions for the threatening events are elicited when negative self-representations are primed; a process that avoids the activation of negative beliefs about the self, reducing discrepancies between actual self and ideals. This
serves to preserve self-esteem and protect against depression. However, the price paid is the belief that others have malevolent intentions, and that the world is a threatening place. Bentall et al.’s (1994) theory follows previous accounts that implicate defence against low self-esteem in paranoid ideation (Zigler & Glick, 1988).

Much research has been undertaken to investigate this theory. Evidence for the type of attribution process described by Bentall and colleagues has been found by several studies. Kaney and Bentall (1989) compared participants with persecutory delusions with depressed and normal participants using Peterson et al.’s (1982) Attributional Style Questionnaire. This asks participants to make attributional statements along scales of internality, stability and globalness for hypothetical positive and negative events. They found that, like depressed participants, those with persecutory delusions tended to make excessively global and stable judgements for negative events. However, whereas those with depression attributed negative events to internal causes, those with persecutory delusions attributed negative events to external causes, and positive events to internal causes, a tendency that Bentall et al. (1994) describe as an exaggeration of the ‘self-serving bias’ observed in the normal population (Tylor, 1988). A similar attribution pattern was discovered by Fear et al. (1996), with paranoid participants diagnosed as suffering from delusional disorder, by Kaney and Bentall (1992) and also by Candido and Romney (1990). Candido and Romney included a paranoid-depressed group, who also appeared to make external attributions for negative events. However, this group’s attributions for positive events fell between the depressed and paranoid group.
Towards a further development of the theory, Kinderman and Bentall (1997) discovered that paranoid participants were more likely to make external-personal (other blaming) rather than external-situational (circumstantial) attributions for negative events. This illustrates the importance of the 'other' in persecutory ideation and implies an interpersonal process. But why do those with paranoia make more external personal attributions, rather than external-situational attributions, which carry a much lower interpersonal cost? Bentall et al. (2001) refer to evidence that in normal individuals high cognitive load has been found to be associated with use of external-personal rather than situational attribution as a kind of 'default', the latter requiring more cognitive effort. This idea may link with the research identifying reasoning and attentional biases amongst paranoid participants (see Garety & Hemsley, 1997).

Other studies have provided less clear-cut accounts of the attributional abnormality predicted by Bentall et al.'s (1994) model, with expected differences between paranoid and non-paranoid patients failing to reach significance (Kreistev, Jackson & Maude, 1999; Martin & Penn, in press, cited in Bentall et al., 2001).

Garety and Freeman (1999) suggest that a key test of the theory, that persecutory delusions serve to defend the self, is whether there is a discrepancy between overt/ explicit and covert/ implicit self-esteem amongst those experiencing persecutory delusions. As highlighted in the previous section, research using the Dysfunctional Attitude Scale indicates that those with persecutory delusions hold
more latent negative core beliefs, especially regarding self-evaluation, than the normal population. However, research investigating the self-reported, or ‘overt’, levels of self-esteem amongst those experiencing persecutory delusions has yielded inconsistent results.

Garety and Freeman (1999) found that paranoid patients had low self-esteem in comparison to reported norms, though a sub-group reported high self-esteem. Bowins and Shugar (1998) also demonstrated that deluded patients suffer from low self-esteem in general. In fact, they reported that in their sample, persecutory delusions and delusions of reference were the most self-diminishing types of delusion, and the more self-diminishing the delusion, the lower self-esteem was found to be. These findings would not be predicted by the hypothesis that persecutory delusions defend against low self-esteem.

Furthermore, if persecutory delusions serve as a defence against depression, then low reported depression would be expected for this group. This does not appear to be the case, with those experiencing persecutory delusions reporting a significantly higher level of depression than non-psychiatric comparison groups (Bentall & Swarbrick, 2001). Furthermore, paranoid delusions secondary to hallucinations have been found to be associated with higher levels of depression than non-paranoid secondary delusions (Chadwick & Birchwood, 1995), and depression has been found to decrease rather than increase when paranoid delusions weaken (Chadwick & Lowe, 1994).
However, in support of the ‘delusion as a defence’ hypothesis, Candido and Romney (1990) identified high self-esteem compared to norms in a paranoid group, low self-esteem in the depressed group and intermediate in the paranoid depressed group; and Lyon, Kaney and Bentall (1994) reported that a paranoid group scored ‘normally’ on a self-esteem scale.

Similarly, using idiographic measures of the self-concept, based on Self Discrepancy Theory (Higgins, 1987), Kinderman and Bentall (1996b) found that participants with persecutory delusions, like normal participants but in contrast to depressed participants, reported actual self-representations that were consistent with their ideals. However, the paranoid group was found to have greater discrepancies between self-perceptions and the believed perception of parents about the self. Bentall et al. (2001) propose that this finding is in accordance with the theory that people with persecutory delusions maintain consistency between their beliefs about themselves and their ideals at the expense of attributing negative beliefs about the self to others.

Furthermore, in an attempt to identify any discrepancy between overt and covert self-esteem, Kinderman (1994) found that paranoid and normal participants endorsed more high self-esteem words than a depressed group on a ‘self concept checklist’, consistent with the prediction that overt self-esteem is high in this group. However, on an emotional Stroop task (Stroop, 1935), which has been found to show that specific clinical groups react differently to threatening information that is directly relevant to their psychopathology (Williams, Matthews & MacLeod, 1996), the paranoid group was slow to colour name high
self-esteem words, and even slower to colour name low self-esteem words. This finding is consistent with the idea that covert low self-esteem is low in this group. This finding was replicated by Lee (2000).

In summary, research investigating the existence of a discrepancy between overt and covert self-esteem amongst those with persecutory delusions has not provided clear support of the 'delusion as a defence' theory. As Garety argues, if persecutory delusions defend against low self-esteem, then surely the overt/reported self esteem of those with persecutory delusions would be consistently high, or within the normal range. However, research has yielded inconsistent results, from low through to high self-reported esteem in paranoid groups, and people with paranoia are commonly found to be depressed. In a review of ten studies investigating the link between paranoia and self-esteem, Garety and Freeman (1999) similarly conclude that no consistent picture emerges. There is some evidence to suggest that those with persecutory delusions harbour latent negative core beliefs, the type often associated with low self-esteem and depression. However, whether or not persecutory delusions serve to protect the individual from activation of these beliefs through exaggeration of the self-serving bias is less clear.

**Interpreting inconsistent findings**

In their review paper, Bentall et al. (2001) consider much of the research cited here, and present three alternative interpretations of the inconsistent findings.
Each of these interpretations will be considered next, with greatest emphasis on the third interpretation, which forms the theoretical basis of the current study.

Firstly, inconsistent results could be due to different conceptualisations of the self across studies, with different studies measuring different concepts. Bentall et al. (2001) argue that correlations between measures of self-representation within the normal population are often moderate, and that measures confounding self-perception and the believed perceptions of the self by others may be particularly problematic when investigating paranoia.

Secondly, Bentall et al. (2001) propose that inconsistent results could be a result of investigator's failure to take into account 'dynamic aspects of the self'. They suggest that self-representations in patients with persecutory delusions may be unstable over time, and that attempts to maintain positive self-representations through externalising biases can often fail. The observation that attributional style in depressed and normal participants can vary over the short and medium term, though it is thought to be more stable over the long term, and that attributional style can determine and be determined by low mood and available self-representations (Bentall et al., 2001), forms the basis for this dynamic model, which Bentall et al. call the 'attribution-self-representation cycle'.

As already discussed, the tendency for paranoid individuals to make external attributions for negative events has been hypothesised by Bentall et al. (1994) to be defensive. The self-ideal of the individual is maintained, but the price paid is that this type of inference will affect that person’s beliefs about others.
representations of themselves. In their ‘attribution-self-representation’ model Bentall et al. (2001) propose that accounts of low mood in paranoia (Bentall & Swarbrick, 2001, Chadwick & Birchwood 1995), and inconsistent findings around reported self-esteem, reflect the fact that sometimes attempts to avoid internal attributions for negative events fail to prevent the individual from being overwhelmed by negative beliefs about the self.

Some support for this theory comes from a study by Kinderman, Prince, Waller and Peters (2003). They compared a group experiencing persecutory delusions, with depressed and 'normal' groups. A modified version of the Self Concept Checklist (Kinderman & Bentall, 2000) was given to the groups both prior to and following administration of an emotional Stroop task aimed at manipulating attentional bias to self-related threat information. Before administration of the Stroop task there were no significant differences between the groups in terms of self-actual: self-ideal and self-actual: other-actual discrepancies. However, after the administration of the Stroop task, reductions in the self-actual: self-ideal discrepancies and increases in the self-actual: other-actual discrepancies were observed for the paranoid participants. Whilst providing support for Bentall et al.'s (1994) model, this study also implies that abnormalities in attribution appear to be dynamic and responsive.

A third interpretation of the inconsistent findings regarding the defence hypothesis is that persecutory delusions only operate as a defensive mechanism for a subgroup of individuals. This interpretation is the one adopted by Trower and Chadwick (1995), and formed the starting point for their theory of two types
of paranoia. It is this theory that forms the basis for the current investigation, and will therefore be considered in detail.

The next section first describes two types of paranoia (Trower & Chadwick, 1995), and looks at evidence to support the distinction. The theorised developmental pathway of the two types is then explained. Finally, differences in the early experience of relationships with care-givers that would be predicted by Trower and Chadwick's (1995) theory are specified.

Two types of paranoia

The assertion that the 'delusion as a defence' hypothesis operates for only a sub-group of those experiencing persecutory delusions has been developed by Trower and Chadwick (1995), who propose that there are two types of Paranoia: 'Poor Me' and 'Bad Me'. Trower and Chadwick's theory comes from an attempt to understand differences within groups experiencing persecutory delusions. For example, in a preliminary study reported by Chadwick and Trower (1995), paranoid and depressed individuals were shown to perceive similar degrees of threat in the form of negative evaluation from others. However, the depressed participants condemned themselves, whereas those with paranoia generally condemned others. This is in line with Bentall et al.'s (1994) theory of an exaggerated self-serving bias. However, 3 of the 11 participants with paranoia responded more like the depressed group, that is they condemned themselves negatively rather than others.
According to Trower and Chadwick (1995), in the case of Poor Me paranoia the individual believes him or herself to be unfairly persecuted. An interpersonal threat is experienced, but it is rejected as undeserved and unjustified, and self-esteem is preserved as the individual negatively evaluates his persecutors. This fits with the 'delusion as a defence' hypothesis. However, in the case of Bad Me paranoia they propose that the individual believes him or herself to be rightfully punished or persecuted because of something that they have done, said or thought, or because they believe that in some way they are a 'bad person'. Again the individual experiences an interpersonal threat, however they accept it and believe they are deserving of it. The self is consciously experienced as bad and worthy, and therefore the reported self-esteem of this group is lower than the Poor Me group who are able to defend against the threat by making an external attribution.

The delusion as a defence hypothesis is not incompatible with the theory that there are two types of paranoia, rather this theory would suggest that the Bad Me sub-group does not employ the exaggerated self-serving bias observed by some studies. Therefore phenomenological differences between the two types are predicted. In Bad Me paranoia the self is consciously experienced as bad and worthy. It would therefore follow that this group would report a higher level of depression, shame and anxiety than the Poor Me group. Alternatively, those experiencing Poor Me paranoia would be expected to defend against low self-esteem by making negative self-other evaluations, resulting in less depression and anxiety, but possibly more anger (Chadwick et al., in press).
Some support for the predicted differences between the two groups comes from Freeman, Garety and Kuipers (2001). They asked 22 people with a diagnosis of schizophrenia (or related disorder) and current persecutory delusions whether they thought they deserved to be harmed. Individuals who replied ‘yes’ to this question were significantly more depressed, had lower self-esteem, and reported a higher number of compliance safety behaviours than those who replied ‘no’ or ‘maybe’.

More direct support comes from a recent study by Chadwick et al. (in press), who showed that the two types could reliably and validly be distinguished by clinicians on the basis of the content of delusional themes alone. They looked at differences between Poor Me and Bad Me groups on the Evaluative Beliefs Scale (Chadwick, Trower & Dagnan, 1999). This scale contains items that measure global and stable negative person evaluations. It has three scales: other-to-self, self-to-self, and self-to-other. Not surprisingly both groups revealed negative other-to-self person evaluations. However, the Poor Me paranoia group evaluated others (self-to-other evaluation) more negatively than the Bad Me group, and the Bad Me group evaluated them self (self-to-self evaluation) more negatively than the Poor Me group. This finding is consistent with the Poor Me/Bad Me theory proposed by Trower and Chadwick (1995). As predicted, the Poor Me group were also found to have higher self esteem and lower levels of depression and anxiety than the group experiencing Bad Me paranoia, although predicted differences between the two groups in terms of anger did not emerge.
Importantly this study also demonstrated that the differences in self-esteem and self-evaluations were not due simply to differences in depression. The Poor Me/Bad Me groups still differed significantly in scores on these two variables even when depression was controlled for. Thus, the Poor Me/Bad Me distinction revealed predictable differences in self-esteem/evaluation which are not due to depression levels, as well as predicting the difference in depression (Chadwick et al., in press).

Chadwick et al. ’s (in press) study also illustrates the importance of including the Bad Me group when investigating persecutory delusions, since the exclusion of participants who believe “that the intended harm should be out of all proportion to any sins or offences committed by the person in the past”, as suggested by Bentall et al. (2001, p. 1148), would have prevented identification of these important phenomological differences.

Chadwick et al. (in press) consider two different interpretations of the phenomological differences between the types. One interpretation is that that their findings could be explained along the lines of Bentall et al. ’s (2001) attribution-self-representation model outlined earlier; that the differences are “snapshots of one paranoid process observed at different points in time” (Chadwick et al., in press, p. 16), and that the Bad Me profile emerges only when the Poor Me defence is weak. Alternatively, Chadwick et al. (in press) propose that the two types represent fundamentally different underlying psychological and dispositional vulnerability due to learning experience over an extended period (Trower, personal correspondence). Indeed, Trower and Chadwick (1995)
propose a comprehensive theory to account for the development of vulnerability to Poor Me and Bad Me paranoia. Their theory is described in the following section.

*Origin of the two types*

Trower and Chadwick (1995) propose that the origins of Poor Me and Bad Me paranoia lie in different experiences of self-construction. They propose a general theory of the self from which a specific theory of paranoia is derived. They identify two types of universal threat to self-construction, which are responded to by one of two types of dysfunctional defence amongst those with paranoid delusions.

Trower and Chadwick base their ideas on Goffman’s (1971) theory that a person continuously constructs his or herself by means of self-presentation performances before an audience. They propose three components of the self: the *objective self*, which is the public, behavioural self observed by others; the *subjective self*, which is the ‘conscious agent’ that chooses and monitors actions, and evaluates feedback; and the *other*, with their own objective and subjective components, who provides the audience to which the objective self is presented, and feedback to the subjective self. Drawing on these components, the process of self-construction can be understood in stages: a self-presentation is performed before the ‘other(s)’ in an attempt to influence how the ‘other(s)’ perceive or treat that individual. Their reaction to the presentation forms the basis of perceived, anticipated or imagined ‘other-to-self’ evaluation. This may lead to an
evaluation by the person of themselves (self-to-self evaluation) or an evaluation by the person of the ‘other(s)’ (self-to-other evaluation). The crucial importance of the presence and role of the ‘other(s)’ in ‘making real’ the objective self and providing feedback for the subjective self is highlighted by Trower and Chadwick.

Perceived threats to self-construction come from this ‘other’. They may take two main forms: insecurity threats come from the other being perceived as constantly neglectful or absent. Thus there is nothing to objectify the individual’s presented self. Although their subjective self is intact, and they have a strong internal desired self, they have no ‘other’ to be a recognising audience. As a result they feel despair and failure, an ‘existential nothingness’ (Trower & Chadwick, 1995). At the other end of the scale, if the ‘other’ does not recognise a self-presentation as freely constructed by the individual, and tries to take possession and control of it, that individual will experience alienation threats. They will feel like an object, defined and labelled by the ‘other’, and experience this through shame and extreme self-consciousness (Trower & Chadwick, 1995).

Trower and Chadwick propose that, primarily through early learning experience, people tend to have a vulnerability for one type of threat which affects beliefs about and responses to the ‘other’s’ perception of them. In extreme cases of threat and vulnerability, paranoia may emerge as a defence: Poor Me paranoia against insecurity threats, and Bad Me against alienation threats.
In the case of Poor Me paranoia the individual is hypothesised to have a history of, and become vulnerable to, insecurity threats. Their self-presentation has been neglected by an objectifying ‘other’. When the other displays indifference or rejection they experience a gap between their actual self and ideal self (Higgins, 1987). In order to close this gap they explain the others actions in terms of persecution, and are likely to respond angrily and pursue. They avoid a negative other-self evaluation becoming a self-self evaluation by condemning the other. Thus their desired self-image is defended. This is an extreme instigation of self-serving bias, a defence they are able to use because their subjective self is intact. This is similar to the kind of paranoia and defence mechanism described by Bentall et al. (1994). Those with Poor Me paranoia will be motivated to maintain their delusional system, and go to extremes to do this because, Trower and Chadwick argue, if this defence were to break down the basis of the self would collapse, and the person would be plunged into ‘existential nothingness’ (Sartre, 1957).

Alternatively, Bad Me paranoia is seen as a response to a history of, and vulnerability to, alienation threats, where an excessively present and over intrusive ‘other’ has taken control of the inadequate or deficient self-presentation. Those with Bad Me paranoia are likely to believe that they are inherently bad or inadequate and deserving of punishment (*negative self-to-self evaluation*). Therefore, whereas the person with Poor Me paranoia’s need is to seek out an ‘other’ to whom they can present their grandiose self, and their defence serves to maintain their desired self, the person with Bad Me paranoia has a need to hide the self at all costs, and their defence is to conceal the ‘bad’
self. Fear of recognition leads to anxiety driven avoidance and hyper-vigilance in order to be ready to take avoidant action. Trower and Chadwick also talk about a more subtle form of avoidance used by this group; that is to present a ‘false self’ that conforms to whatever they imagine the other desires them to be, in an attempt to hide the shameful ‘bad’ self. Others are perceived as enormously threatening and powerful, and the self as weak. Through cognitive biases linked with the ‘bad’ core beliefs about the self, most of the others behaviour will be perceived as a critical other-to-self evaluation. Trower and Chadwick propose that, following recognition by an ‘other’, those with Bad Me paranoia experience high self-consciousness and shame, a desire to escape and depression, marked by helplessness and hopelessness.

Gilbert (1989, 1992) suggests that shame is related to rank and status judgments of feeling inferior, powerless or bad in comparison to others. In shame there is something bad or worthless about oneself (Gilbert, 1997). It therefore seems likely that the experience of shame would come with alienation threats to self-construction, where a self-presentation is labelled as no good and taken possession of by an objective and powerful ‘other’. On the other hand, when a self-presentation is not recognised, as in the process of insecurity threats to self-construction, there is no objectifying ‘other’ to label the self as inferior or bad, or indeed anything at all. Thus shame would not be experienced.

In furtherance of their theory that the origin of the two types lies in different historical experiences of self-construction, and considering the crucial importance of the role of the ‘other’ in self-construction, Trower and Chadwick
propose different experiences of early relationships with care-givers in the Poor Me and Bad Me sub-types (Trower & Chadwick, 1995). The next section considers how the two group’s experiences with care-givers would differ, based on Trower and Chadwick’s theory, and how this difference could be identified empirically.

Examining the experience of early relationships in the two types

Parker, Tupling and Brown (1979) reviewed the literature on parental qualities associated with normal development (see Ainsworth et al., 1975; Bowlby, 1969; Rutter, 1972) and looked at factor analyses of parental behaviours and attitudes (Roe & Seligman, 1963; Ruskin et al., 1971; Schaefer, 1965, cited in Parker et al., 1979) in an attempt to examine the parental contribution to a ‘parent-child bond’. Two principal dimensions emerged: a ‘care’ dimension and a dimension of psychological control over the child (overprotection). Parker et al. (1979) went on to develop a measure of perceived parental characteristics (the Parental Bonding Instrument: PBI), which crosses the care and overprotection dimensions, placing an individual in one of four quadrants: ‘optimal parenting’ (high care, low overprotection), ‘affectionate constraint’ (high care, high overprotection), ‘affectionless control’ (low care, high overprotection), and ‘neglect’ (low care, low overprotection). The affectionless control’ and ‘neglect’ quadrants along the overprotection scale conceptually appear to map closely on to an early experience of alienation and insecurity threats to self-construction, respectively. It would therefore be expected that ‘affectionless control’ would be observed amongst a Bad Me type paranoia group, whilst a Poor Me type paranoia group
would be more likely to experience ‘neglect’. Drayton, Birchwood and Trower (1998) used the PBI with a sample of people with psychosis, and demonstrated that they reported their parents as being less caring and more overprotective than a normal population. It might therefore be expected that a group of participants experiencing persecutory delusions would also report their parents as being less caring than the normal population. However, according to Trower and Chadwick’s (1995) theory, the two types of paranoia could be differentiated along the ‘overprotection’ scale. Indeed, Trower and Chadwick state that they would expect those experiencing Poor Me paranoia to have experienced much neglect, rejection and abandonment (‘neglect’), and those experiencing Bad Me paranoia to have experienced much criticism, hostility and intrusive control (‘affectionless control’).

To summarise Trower and Chadwick’s (1995) theory, those with Bad Me (self-blaming) paranoia are proposed to experience over-intrusive relationships with care-givers, and alienation threats to self-construction in their early years. Bad Me paranoia is a defence against deficient, ‘bad’ self-beliefs and related to the experience of depression, anxiety and low self-esteem. Those with Poor Me (other blaming) paranoia are proposed to experience neglectful care-givers, and insecurity threats to self-construction in their early years. Poor Me paranoia serves to defend the individual against discrepancies between actual and ideal self-representations, and is associated with higher self-esteem and lower depression, anxiety and shame.
The current study

The study by Chadwick et al. (in press) goes some way towards examining theorised phenomenological differences between the two types of paranoia. However, other predicted differences between the groups, and the theorised differences in self-construction and early relationships giving rise to the two types, has not yet been investigated. This is an interesting issue, both theoretically and clinically. The next section will describe the broad aims of the current study, and then list specific hypotheses to be tested.

Initially, the study aims to reliably distinguish the two types of paranoia based on the content of participants’ delusions.

Secondly, Trower and Chadwick (1995) propose that Poor Me paranoia could reflect a history of interpersonal neglect, and thus vulnerability to insecurity threats to self-construction, whilst Bad Me paranoia could reflect a history of interpersonal control or intrusion and thus vulnerability to alienation threats to self-construction. This would suggest a disposition to either Poor Me or Bad Me paranoia. Alternatively, Bentall et al. (2001) have suggested that phenomenological differences amongst those experiencing paranoia reflect an ‘attribution-self-representation cycle’; a dynamic process from Poor Me to Bad Me and back again depending on internal and external situational triggers. In line with the disposition hypothesis, this study aims to identify whether delusional content (Poor Me verses Bad Me paranoia) is associated with the theorised
different types of early relationships, and vulnerability to different types of threat to self-construction. These predicted differences have not previously been tested.

Finally, in line with Trower and Chadwick’s theoretical framework, it is also proposed that those who believe that they are deserving of punishment (Bad Me paranoia) will experience more depression and shame than those who feel unfairly persecuted (Poor Me paranoia). Of interest was whether or not the differences in depression found by Chadwick et al. (in press) would be replicated. The hypothesised difference in shame has not previously been tested.

Hypotheses

_Hypothesis 1_

The Bad Me paranoia group will score more highly on the ‘overprotection’ dimension of the Parental Bonding Instrument (PBI: Parker, Tupling & Brown, 1979) towards the affectionless control quadrant, than Poor Me paranoia group, whose scores will tend to lie in the ‘neglect’ quadrant.

_Hypothesis 2_

The Poor Me group will report greater vulnerability to insecurity threats, whereas the Bad Me group will be more vulnerable to alienation threats, as measured by The Self and Other Scale (SOS: Dagnan, Trower & Gilbert, 2002).
Hypothesis 3

The Bad Me paranoia group will report more depression than the Poor Me paranoia group, as measured by The Beck Depression Inventory (BDI; Beck & Steer, 1987).

Hypothesis 4

The Bad Me paranoia group will report more shame than the Poor Me group, as measured by the Experience of Shame Scale (ESS: Andrews, Quian & Valantine, 2002).

Hypothesis 5

The possibility that the Bad Me group is responding in what they perceive to be a socially desirable manner, in an attempt to hide their 'bad' self, and thus presenting a 'false self' needs to be considered. In this instance self-report data would not be valid. It is predicted that there will be no significant difference between the two groups on a measure of socially desirable responding (EPQ-LS; Eysenck & Eysenck, 1975)
Hypothesis 6

According to Trower and Chadwick’s theory of self-construction, the Poor Me group’s ‘subjective self’ will be characteristically narcissistic (Trower & Chadwick, 1995). This group will therefore score more highly on the ‘Grandiose Delusions’ sub-scale of the Scale for Assessment of Positive Symptoms (SAPS: Andreasen, 1984) than the Poor Me group.
Chapter Two
Method

Overview

This is a questionnaire-based study, using a cross-sectional group comparison design to examine the differences between 'Poor Me' and 'Bad Me' paranoia participants on measures of 'overprotection' and 'care' in early relationships with care-givers; vulnerability to 'alienation' and 'insecurity' threats to self-construction; depression; shame and tendency to respond in a socially desirable manner.

Participants

Participants were recruited from inpatient wards and outpatient clinics attached to two large inner-city London hospitals. Inclusion criteria consisted of (1) over 18 years old, (2) currently experiencing persecutory delusions, as defined by Freeman and Garety (2000) and (3) able to give informed consent. The exclusion criteria consisted of (1) organic or drug induced psychosis and (2) currently too severely delusional to participate.

An anticipated sample size of 21 per group was calculated based on Chadwick et al.'s (in press) study, which found an effect size of 0.9 in relation to depression. A total sample of 42 participants was required to have 80% power to detect a significant mean difference in depression at alpha = 0.05.
Initially identification of potential participants was achieved through liaison with health care professionals (Consultant Psychiatrists, Senior House Officers, Specialist Registrars, Clinical Psychologists and Psychiatric Nurses), who were asked to consider people they knew to be currently experiencing persecutory delusions, and reference to patient records. However, at the point where a sample of 27 participants had been gathered it was noted that only six of these were classified as experiencing Bad Me paranoia, whilst 21 were classified as experiencing Poor Me paranoia (see below for classification procedure). A decision was made to actively try and identify potential participants experiencing Bad Me paranoia, and a letter was sent to health care professionals asking for their assistance in this process (appendix 1). Twelve potential participants were identified in this way, nine of whom fitted the inclusion/ exclusion criteria and were seen as part of the study.

Due to recruitment difficulties, a total of 36 participants took part in the study (18 male, 18 female), falling slightly short of the sample size indicated by the power calculation. Those who were approached but refused to take part often seemed suspicious of the research. Other reasons given for not taking part included feeling too tired or lethargic (‘can’t be bothered’), ‘not in the mood’ and simply ‘not interested’. The attrition rate was approximately 30%.

The mean age of the participants was 35.3 (range 22- 58). Of the 36 participants that took part, 32 were currently on inpatient wards (16 male, 16 female), and four were seen in outpatient clinics (two male, two female).
Reference to the clinical notes was made to determine the primary diagnosis given to participants, and all information on diagnosis of participants is summarised in Table 1. In terms of ethnicity, 47% were white British or Irish, 50% were black or black British and 3% were Asian or Asian British.

The procedure for categorising participants as experiencing Bad Me or Poor Me paranoia is outlined later in this chapter. A total of 21 participants were categorised as experiencing Poor Me paranoia (11 male, 10 female), and 15 as experiencing Bad Me paranoia (7 male, 8 female). It was not possible to categorise one participant and so their data was excluded. For the Poor Me group the mean age was 35.3 (range 22- 58). For the Bad Me group the mean age was 35.5 (range 22- 49). There was no significant difference between the two groups in terms of gender ($X^2(1)= 0.11, p= 0.74$), age ($t (24)< -0.01, p= 1.00$) or ethnicity ($X^2(2)= 3.74, p= 0.15$). All 21 participants in the Poor Me group were currently on inpatient wards, whilst four of the 15 participants in the Bad Me group were seen in outpatient clinics. As can be seen from Table 1, the pattern of diagnoses in the two groups is broadly similar.
Table 1. Diagnoses of the total sample and each group.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total group</th>
<th>Poor Me group</th>
<th>Bad Me group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid Schizophrenia</td>
<td>12 (33%)</td>
<td>7 (20%)</td>
<td>5 (14%)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>5 (14%)</td>
<td>3 (8%)</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Bi-Polar Disorder</td>
<td>3 (8%)</td>
<td>2 (6%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Schizo-Affective Disorder</td>
<td>4 (11%)</td>
<td>4 (11%)</td>
<td>0</td>
</tr>
<tr>
<td>Psychotic Depression</td>
<td>1 (3%)</td>
<td>0</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>‘Psychotic Illness’</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>0</td>
</tr>
<tr>
<td>No information available</td>
<td>10 (28%)</td>
<td>4 (11%)</td>
<td>6 (17%)</td>
</tr>
</tbody>
</table>

Numbers in brackets represent percentage of the total sample.

Finally, data was collected on the severity of participants’ delusions using the Scale for Assessment of Positive Symptoms (SAPS). Details of this scale are provided in the next section. No significant difference between the two groups was found in relation to severity of persecutory delusions ($t(24)= 0.48, p= 0.64$) or global rating of severity of delusions ($t(34)= 0.79, p= 0.44$).

**Categorisation Procedure**

Participants were interviewed using the ‘Delusions’ section of the Scale for Assessment of Positive Symptoms (SAPS: Andreasen, 1984, appendix 4). This structured interview allows for the researcher to rate the severity of participants’ individual delusions (for example persecutory delusions, grandiose delusions, delusions of sin and guilt) and the overall (‘global’) severity of delusions on a six-point scale. The SAPS has been found to have good psychometric properties.
(Andreasen, Flaum, & Ardt, 1992). Supplementary question addressing whether or not the punishment was thought to be deserved was asked when the participant was describing persecutory delusions (“Why do you think this is happening to you?” “Is there any reason you think you might deserve this?”).

Participants were categorised as experiencing ‘Bad Me’ or ‘Poor Me’ paranoia on the basis of the content of their persecutory beliefs. Participants who believed that they in some way deserved punishment were included in the ‘Bad Me’ group, and those who believed that persecution was unjustified were included in the ‘Poor Me’ group. In some cases it was not absolutely clear whether the participant believed they deserved their punishment, for example where a contradictory answer was given. This was to be expected, considering the Bad Me groups theorised motivation to conceal a shameful self, and is discussed further in chapter four. The direction of the rating went towards what appeared to be the most firmly held belief in these cases. There is evidence to show that ratings of the contents of delusions by professionals can be made reliably (Startup et al., 2003).

In order to establish the reliability of categorisation in this study, participants’ responses to key questions on the SAPS were transcribed verbatim and coded by the researcher and an independent blind rater. The inter-rater reliability between the two raters was good (Cohen’s kappa = 0.89).

Previous studies have suggested looking at the presence of high self-esteem to help with the categorisation process, as this is considered to be associated with
Poor Me paranoia. However, it was thought that using self-esteem to help identify the two types might prove rather circular in this case since the emotional experience of each group was one of the dependent variables. Categorisation was therefore made on the basis of thought content alone.

**Procedure**

Once potential participants were identified, they were invited to meet with the researcher to discuss the study. At this meeting they were given information about the study (see appendix 2) and an opportunity to ask questions before deciding whether to take part or not.

For participants who agreed to take part, the ‘Delusions’ section of the Scale for Assessment of Positive Symptoms (SAPS) was administered, followed by a series of questionnaires. Guidelines were given for each questionnaire, and participants were given the option to fill in them in alone or with the help of the researcher. Assistance was always given where there were literacy problems. Participants were given £10 as remuneration for their time.

**Ethical Issues**

Ethical approval from two committees (see appendix 3 for approval letters) and permission from the Responsible Medical Officer (R.M.O) for each participant was gained.
Participants were informed at the beginning of the session that if, during the meeting, they revealed information that led the researcher to be concerned about the participant’s own or others safety, this information would have to be shared with a member of the ward staff.

Measures

The Parental Bonding instrument (PBI: Parker, Tupling and Brown, 1979, Appendix 5). This scale assesses early attachment experience. It is a simple self-report measure for which there are general population norms available (Parker et al., 1979) and which has been found to be reliable and valid even after controlling for the effects of current mood state, psychiatric status and social desirability (Brewin, Andrews & Gotlib, 1993; Parker, 1989). It asks participants to rate their agreement with statements about their parents’ attitude and behaviour towards them during the first 16 years of life, for example ‘My parents let me make my own decisions’, on a four point scale (very like, moderately like, moderately unlike or very unlike my parents). The original instrument consists of 25 items which the participant considers firstly for their mother and secondly for their father. For ease of completion, this study asked participants to consider the 25 items only once for their main care-giver(s). Twelve items tap ‘care-giving’ (affection, emotional warmth and empathy), with scores ranging from 0- 36, and thirteen tap ‘overprotection’ (intrusion, excessive contact, control, infantalisation and prevention of independent behaviour), with scores ranging from 0- 39. These two scales can be combined to represent experience of different parenting styles: high care scores and low overprotection.
scores are thought to represent optimal parenting, whilst both high care and overprotection scores are thought to represent 'affectionate constraint'. Low care and low overprotection scores are thought to represent 'neglect', whilst low care and high overprotection scores are thought to represent 'affectionless constraint' (Parker et al., 1979).

The Beck Depression Inventory (BDI: Beck and Steer, 1987). This widely used measure is a twenty-one item self-report scale for which there are general population norms available. The scale asks participants to consider four statements for each of the items ('sadness', 'pessimism' etc). The participant is asked to endorse the statement that best describes them when considering their experience over the past two weeks. Scores for each item range from 0-3, and total scale scores range from 0-63, with high scores being indicative of depression. The BDI is not indicative of the full clinical syndrome of depression, but it is a reliable and well-validated measure of depressive symptomatology in both clinical and non-clinical samples (Beck, Steer & Garbin, 1988).

The Experience of Shame Scale (ESS: Andrews, Quian and Valantine, 2002, Appendix 6). This twenty-five item scale assesses eight specific areas of shame (shame of personal habits, manner with others, sort of person [you are], personal ability, shame about doing something wrong, saying something stupid, failure in competitive situations and feeling ashamed of [your] body or any part of it). For each of the eight shame areas covered, there is a question addressing the experiential component (e.g. 'Have you felt ashamed of your ability to do things?'), a cognitive component (e.g. 'Have you worried about what other
people think of your ability to do things?') and a behavioural component (e.g. 'Have you avoided other people because of your inability to do things?'). There are two questions addressing the behavioural component of bodily shame. Participants are asked to respond according to how they have felt over the last year on a scale of one to four ('not at all', 'a little', 'moderately' or 'very much'), with scores ranging from 25-100. The scale has been shown to have good psychometric properties (Andrews et al., 2002), with high internal consistency (Cronbach's alpha = .92), and test-retest reliability of .83. The ESS has been shown to be less prone to mood state effects than more general measures of shame (Andrews et al., 2002).

**The Self and Other Scale (SOS: Dagnan, Trower and Gilbert, 2002, Appendix7).** This scale comprises two seven-item sub-scales, which measure perceived alienation and insecurity threats to self-construction (see Trower & Chadwick, 1995). Participants are asked to respond to a series of statements such as 'I am nothing without certain special other people' (insecurity threat) or 'I dread being under someone else’s control' (alienation threat) by stating the degree to which they endorse that statement on a five-point scale ('strongly agree', 'agree slightly', 'unsure', 'disagree slightly' or 'strongly disagree'). The scale has been found to have good psychometric properties (Dexter-Smith, Trower, Oyebode & Dagnan 2003). Both subscales have good internal reliability (alpha = .77 for the insecurity sub-scale and .82 for the alienation sub-scale) and the scale also has high test-retest reliability (.81 for the insecurity sub-scale and .73 for the alienation sub-scale).
The Eysenck Personality Questionnaire, Social Desirability Scale (EPQ-LS: Eysenck and Eysenck, 1975, Appendix 8). A sub-scale of the Eysenck Personality Inventory, the Lie Scale (LS) attempts to measure participants tendency to 'fake good'. Participants are asked to respond 'yes' or 'no' to a series of 20 questions with a socially desirable response, for example 'Do you always practice what you preach?' or 'Have you ever cheated at a game?'. High scores represent a tendency to dissimulate. The LS has good psychometric properties (Eysenck & Eysenck, 1975), with test-retest reliability of .84, and good internal consistency for both males (alpha = .81) and females (alpha = .79).
Chapter 3
Results

Overview

The first section of this chapter addresses data checking. Following this, group comparisons are made, establishing whether predicted differences between the Bad Me and Poor Me groups were found. Finally, the inter-relationship between dependent variables is examined.

Data checking

Data screening

For each variable the skewness and kurtosis of the distribution was found not to differ significantly from zero. Since the departures from normality were not great, t-test results will be reported throughout. Results were checked by also using a Mann Whitney U-test, which yielded highly similar values. Finally, the data set was examined for outliers. None were identified.

Missing data

Scores for the Parental Bonding Instrument (PBI) are missing for two participants in the Poor Me group: one chose not complete the PBI, stating that they did ‘not want to talk about their childhood any more’, and one completed
the PBI, but their answers were treated as invalid because they gave the same response for each item.

One participant in the Bad Me group withdrew before they had completed all the scales. There is therefore no SOS, ESS or LS data for this participant, though they did consent to have their PBI scores used.

**Group comparisons**

A summary of the mean differences between groups is presented in Table 2. As the direction of difference was predicted by the hypotheses, *p* values for one-tailed tests are reported for group comparisons. Where possible, norms from standardised samples are also presented in an attempt to understand the clinical significance of differences between the two groups.
Table 2. Comparisons between the Poor Me and Bad Me groups.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Poor Me Mean (SD)</th>
<th>Bad Me Mean (SD)</th>
<th>t</th>
<th>p (1-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBI: Overprotection</td>
<td>18.32 (7.17)</td>
<td>22.99 (7.07)</td>
<td>1.90</td>
<td>0.034*</td>
</tr>
<tr>
<td>PBI: Care</td>
<td>17.29 (12.1)</td>
<td>17.30 (10.47)</td>
<td>0.01</td>
<td>0.499</td>
</tr>
<tr>
<td>SOS: Alienation Threats</td>
<td>23.19 (7.16)</td>
<td>26.05 (6.98)</td>
<td>1.17</td>
<td>0.126</td>
</tr>
<tr>
<td>SOS: Insecurity Threats</td>
<td>20.00 (6.66)</td>
<td>18.79 (6.92)</td>
<td>0.52</td>
<td>0.303</td>
</tr>
<tr>
<td>BDI: Depression</td>
<td>17.08 (11.11)</td>
<td>33.20 (12.37)</td>
<td>4.10</td>
<td>0.001***</td>
</tr>
<tr>
<td>ESS: Shame</td>
<td>50.07 (18.68)</td>
<td>68.00 (20.68)</td>
<td>2.67</td>
<td>0.006**</td>
</tr>
<tr>
<td>LS: Socially desirable responding</td>
<td>9.48 (4.25)</td>
<td>8.50 (3.92)</td>
<td>0.69</td>
<td>0.249</td>
</tr>
</tbody>
</table>

*p<0.05; **p<0.01; ***p<0.001

N varied between 19-21 for the Poor Me group and 14-15 for the Bad Me group, and therefore the degrees of freedom for the t-test ranged from 32-34.
Hypothesis 1: early experience of relationships

'The Bad Me paranoia group will score more highly on the 'overprotection' dimension of the Parental Bonding Instrument, towards the 'affectionless control' quadrant, than the Poor Me paranoia group, whose scores will tend to lie in the 'neglect' quadrant.'

Table 2 illustrates that, as predicted, the Bad Me group reported significantly more overprotection in their early relationship with their parents than the Poor Me group. Care scores were almost identical across the Bad Me and Poor Me groups.

As illustrated in Table 3, both groups mean score for overprotection was noticeably higher than the average maternal and paternal overprotection reported by a 'normal' population (Parker et al., 1983). They were also higher than the means reported for Parker, Fairley, Greenwood, Jurd and Silove's (1982) schizophrenic group. The mean overprotection score for the Poor Me group was more comparable with Drayton et al.'s (1998) sample of participants diagnosed with schizophrenia.

Both groups mean care scores were also considerably lower than the norm established by Parker et al. (1983) and the means they established when studying a group of people with schizophrenia. The mean care score for both groups was
more comparable with the ‘paternal care’ mean score of Drayton et al.’s (1998) sample of participants diagnosed with schizophrenia (see Table 3).

Table 3. Group scores on the PBI compared with general population means and earlier studies of people with psychosis

<table>
<thead>
<tr>
<th></th>
<th>Population norms (Parker, 1983)</th>
<th>Schizophrenic group (Parker et al. 1982)</th>
<th>Schizophrenic group (Drayton et al., 1998)</th>
<th>Bad Me group</th>
<th>Poor Me group (Present study)</th>
<th>Total group</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>410</td>
<td>72</td>
<td>36</td>
<td>15</td>
<td>19</td>
<td>34</td>
</tr>
<tr>
<td>Mean PBI score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Overprotection</td>
<td>12.4</td>
<td>14.7</td>
<td>16.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Overprotection</td>
<td>13.3</td>
<td>14.7</td>
<td>18.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General overprotection</td>
<td></td>
<td></td>
<td></td>
<td>23.0</td>
<td>18.3</td>
<td>20.4</td>
</tr>
<tr>
<td>Paternal Care</td>
<td>23.8</td>
<td>20.5</td>
<td>17.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Care</td>
<td>26.9</td>
<td>23.6</td>
<td>22.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Care</td>
<td></td>
<td></td>
<td></td>
<td>17.3</td>
<td>17.3</td>
<td>17.3</td>
</tr>
</tbody>
</table>

Overall, participants’ response on the PBI was comparable to Drayton et al.’s (1998) study, in that participants tended to place their experience of their relationship with their parents in the ‘affectionless control’ quadrant (see Figure 1), with both groups reporting lower care and higher overprotection scores than the norms reported by Parker et al. (1983). Thus, the hypothesis that those with Poor Me paranoia would be more likely to fall in the ‘neglect’ quadrant of parenting was not upheld. However, it does appear to be the case that the two groups can be differentiated along the ‘overprotection’ scale, with participants
experiencing Bad Me paranoia reporting significantly higher levels of overprotection.

Fig. 1: Approximate location of Poor Me and Bad Me groups in the PBI quadrants (care and overprotection scales cross approximately at the general population norms established by Parker, 1983).

Hypothesis 2: threats to self-construction

'The Poor Me group will report greater vulnerability to insecurity threats, whereas the Bad Me group will be more vulnerable to alienation threats, as measured by The Self and Other Scale (SOS)'.

Table 2 illustrates that, although mean scores differed in the predicted direction, there was no significant difference between the two groups on the SOS for alienation or insecurity threats to self-construction.
Both groups' mean score for alienation and insecurity threats were higher than that of the normative, non-clinical sample collected by Dexter-Smith et al. (2003). This standardised population had a mean of 16.95 (s.d. 5.65) for insecurity threats and (18.97, s.d. 6.72) for alienation threats.

**Hypothesis 3: depression**

*The Bad Me paranoia group will report more depression than the Poor Me paranoia group, as measured by The Beck Depression Inventory (BDI).*

Table 2 illustrates that, as predicted, the Bad Me paranoia group reported significantly higher scores on the BDI than the Poor Me group. The mean score within the Bad Me group (33.2), is indicative of severe depression (BDI score >31), whilst the Poor Me group’s mean score (17.08) was within the range of ‘mild depression’ (BDI score 11-20).

**Hypothesis 4: shame**

*The Bad Me paranoia group will report more shame than the Poor Me group, as measured by the Experience of Shame Scale (ESS).*

Table 2 illustrates that, as predicted, the Bad Me group reported significantly higher scores on the ESS than the Poor Me group. The Bad Me group’s mean score was also higher than that of the non-clinical (predominantly female) undergraduate population reported by Andrews et al. (2002), which had a mean
score of 55.58 (s.d. = 13.95). However, the Poor Me group’s mean shame score was lower than this non-clinical sample.

**Hypothesis 5: presentation of a ‘false self’**

‘There will be no significant difference between the two groups on a measure of socially desirable responding: The Lie Scale (LS).’

As shown by Table 2, there is no significant difference between the two groups on the Lie Scale.

**Hypothesis 6: Delusional Content.**

‘The Poor Me group will score more highly on the ‘Grandiose Delusions’ sub-scale of the SAPS’.

As predicted, the Poor Me group reported significantly higher scores on the ‘grandiose delusions’ sub-scale of the SAPS than the Bad Me group (t(34) = 1.74, p=0.045).
Correlation between dependent variables

The variables used in the study were correlated with one another for each group in an attempt to explore how the groups differed. The degree of correlation between dependent variables is illustrated in Table 4. Interestingly, several scales are significantly correlated within the Poor Me group, but not the Bad Me group.

Correlations between scales within the Poor Me Group.

‘Care’ and ‘Overprotection’ measured by the PBI have been reported to be negatively correlated in the normal population, with care scores decreasing as overprotection scores increase (Parker et al., 1983). This study also found the two scales to be significantly negatively correlated within the Poor Me group (r = -0.587, p = 0.008), but not the Bad Me group (r = 0.032, p = 0.911). This may suggest something qualitatively different about the Bad Me group’s early experience of relationships.

Care, measured by the PBI, and alienation threats, measured by the SOS, were also found to be negatively correlated in the Poor Me group (r = -0.576, p = 0.01) but not the Bad Me group (r = -0.152, p = 0.603).

Within the Poor Me group depression, measured by the BDI, was significantly positively correlated with both overprotection, measured by the PBI (r = 0.558, p = 0.013) and shame, measured by the ESS (r = 0.579, p = 0.006). Shame and depression have also been found to be correlated in the normal population (Andrews et al., 2002). However, depression was not found to be significantly
correlated with overprotection or shame within the Bad Me Group (r = 0.338, p = 0.170 and r = 0.197, p = 0.501 respectively).

A statistically significant negative correlation between socially desirable responding, measured by the LS, and shame, measured by the ESS was observed within the Poor Me group (r = -0.481, p = 0.027). Again, this correlation was not observed within the Bad Me group (r = -0.057, p = 0.847).

**Correlations between scales within the Bad Me group.**

Only one statistically significant correlation between scales was observed within the Bad Me group; this was between overprotection, measured by the PBI, and shame, measured by the ESS (r = 0.634, p = 0.015). Interestingly this relationship was not observed within the Poor Me group (r = 0.255, p = 0.292).
Table 4. Correlations between scales for the Poor Me and Bad Me groups.

<table>
<thead>
<tr>
<th>Poor Me Group</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. PBI: Overprotection</td>
<td>-</td>
<td>-0.59**</td>
<td>0.45</td>
<td>-0.29</td>
<td>0.26</td>
<td>0.56*</td>
<td>-0.12</td>
</tr>
<tr>
<td>2. PBI: Care</td>
<td></td>
<td>-</td>
<td>-0.58**</td>
<td>0.10</td>
<td>0.03</td>
<td>-0.39</td>
<td>-0.34</td>
</tr>
<tr>
<td>3. SOS: Alienation Threats</td>
<td>-</td>
<td>0.4</td>
<td>0.1</td>
<td>0.26</td>
<td></td>
<td>-0.29</td>
<td></td>
</tr>
<tr>
<td>4. SOS: Insecurity Threats</td>
<td>-</td>
<td>0.27</td>
<td>0.16</td>
<td></td>
<td></td>
<td>-0.33</td>
<td></td>
</tr>
<tr>
<td>5. ESS: Shame</td>
<td></td>
<td></td>
<td></td>
<td>-</td>
<td>0.58**</td>
<td>-0.48*</td>
<td></td>
</tr>
<tr>
<td>6. BDI: Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-</td>
<td>0.006</td>
<td></td>
</tr>
<tr>
<td>7. LS: Socially desirable Responding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bad Me Group</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. PBI: Overprotection</td>
<td>-</td>
<td>0.03</td>
<td>0.39</td>
<td>0.4</td>
<td>0.63*</td>
<td>0.36</td>
<td>0.48</td>
</tr>
<tr>
<td>2. PBI: Care</td>
<td></td>
<td>-</td>
<td>-0.15</td>
<td>0.16</td>
<td>-0.16</td>
<td>-0.23</td>
<td>0.02</td>
</tr>
<tr>
<td>3. SOS: Alienation Threats</td>
<td>-</td>
<td>0.09</td>
<td>0.42</td>
<td>0.39</td>
<td></td>
<td>-0.01</td>
<td></td>
</tr>
<tr>
<td>4. SOS: Insecurity Threats</td>
<td>-</td>
<td>0.43</td>
<td>0.18</td>
<td>0.07</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. ESS: Shame</td>
<td></td>
<td>-</td>
<td></td>
<td>0.2</td>
<td></td>
<td>-0.06</td>
<td></td>
</tr>
<tr>
<td>6. BDI: Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-</td>
<td></td>
<td>-0.16</td>
</tr>
<tr>
<td>7. LS: Socially desirable Responding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < 0.05; ** p < 0.01 (2-tailed)

N varied between 19-21 for the Poor Me group and 14-15 for the Bad Me group.
Disruption of the normal correlation between Alienation and Insecurity threats to self-construction.

Dexter-Smith et al. (2003) discovered a significant positive correlation between the alienation and insecurity threat sub-scales on the SOS within the normal population. However, the scales were not found to be correlated for either group in the present study.

In summary, predicted differences between the two groups on measures of overprotection, depression, shame and grandiosity were observed. However, whilst reporting less overprotection than the Bad Me group, the Poor Me group still reported more overprotection than the general population norm, and thus their scores did not fall in the ‘neglect’ quadrant of the PBI. In addition, no significant difference in either type of threat to self-construction was detected. The relationship between several variables was found to be significant within the Poor Me group. Some of these relationships might be expected, for example if looking at a normal population. However, these variables were not found to be correlated within the Bad Me group. Interpretation of these results is considered in Chapter four.
Chapter 4
Discussion

Overview

Using a cross-sectional group comparison design, this study set out to test theoretical predictions arising from the distinction between two types of persecutory delusions: Poor Me and Bad Me paranoia (Trower & Chadwick, 1995). Specifically, it has been proposed that the two types can be related to early experience of relationships and vulnerability to different types of threat to self-construction (Trower & Chadwick, 1995). Against this theoretical context, further predictions about the current emotional experience of the two types are implied.

This chapter will first briefly review the theoretical basis for the hypotheses examined by the study. Secondly the study’s findings for each hypothesis are summarised and the relationship between dependent variables for each is group is examined. Following this the study’s findings as a whole are interpreted against the context of existing theory and research. Finally the strengths and weaknesses of the study are examined, ideas for future work are considered and the professional implications of the current study are outlined.
The theory revisited

**Bad Me paranoia**

In line with Trower and Chadwick’s (1995) theory this study hypothesised that the ‘Bad Me’ group would have experienced early primary relationships characterised by low care (affection, emotional warmth and empathy) and high ‘overprotection’ (intrusion, excessive contact, control, infantalisation and prevention of independent behaviour), referred to by Parker et al. (1979) as ‘affectionless control’. It was predicted that this type of relationship would be associated with a vulnerability to alienation threats to self-construction. According to Trower and Chadwick, this is where an individual’s ‘objective’ (presented) self is rejected by the ‘other’, and a foreign, ‘alien’, self is imposed upon them. Continued participation in this type of interpersonal dynamic, where the self-presentation is repeatedly rejected, leads the individual to believe that they are inherently bad or inadequate and thus deserving of punishment. They experience shame and self-consciousness. Trower and Chadwick propose that, through cognitive biases linked with their ‘bad’ core beliefs about the self, most ‘other(s)’ behaviour is perceived by the Bad Me group as a critical evaluation of the self. In its extreme, this is manifested as Bad Me paranoia; persecutory delusions where the individual believes that they deserve their punishment, and because of this they feel depressed.
Poor Me paranoia

This study proposed that the Poor Me group would report an experience of low care and low overprotection (allowance of independence and autonomy) in their early relationships. This might reflect a kind of indifferent or absent care-giving style, described by Parker et al. (1979) as 'neglect'. It was thought that this type of early relationship would be linked with a vulnerability to what Trower and Chadwick (1995) call insecurity threats to self-construction. Here the 'other' continuously fails to recognise, or is indifferent to, an individual's objective (presented) self. Whilst they have a strong, almost narcissistic, grandiose desired self, this is neglected by an objectifying 'other', which leads them to experience a gap between their desired and realised self. In order to close this gap they use an exaggeration of the self-serving bias; they make external attributions by explaining others' actions in terms of persecution. This enables maintenance of the individual's desired self and thus defends against depression. According to Chadwick and Trower (1995) this is the basis of Poor Me paranoia; the individual experiences persecutory delusions and believes that their punishment is unjust, that they do not deserve it. Poor Me paranoia is similar to Bentall et al.'s (1994) model of persecutory delusions as a defence against depression.

The current study tested specific predicted differences between Poor Me and Bad Me paranoia groups based on Trower and Chadwick's (1995) theory. Findings for each hypothesis are summarised in the next section.
Predicted differences between the two groups

Hypothesis 1: early experience of relationships

Hypothesis one stated that the Bad Me paranoia group would score more highly on the 'overprotection' dimension of the Parental Bonding Instrument (PBI), towards the 'affectionless control' quadrant (low care, high overprotection), than the Poor Me paranoia group, whose scores would tend to lie in the 'neglect' quadrant (low care, low overprotection).

This study found that there was no difference between the two groups in terms of 'care', and both groups’ mean 'care' score was considerably lower than the average maternal and paternal 'care' reported by a 'normal' population (Parker et al. 1983). As predicted, the Bad Me group reported significantly more overprotection during childhood than the Poor Me group. However, both groups’ mean overprotection score was notably higher than the non-clinical norm established by Parker (1983). This means that the Poor Me group’s scores did not lie in the 'neglect' quadrant, as predicted. Rather both groups scores fell within the 'affectionless control' quadrant. A similar pattern of responding has been observed by studies looking at groups of patients with schizophrenia (Drayton et al. 1998, Parker et al. 1982). However, the Bad Me group were positioned much further along the overprotection scale of the 'affectionless control' quadrant than the Poor Me group, whose scores fell closer to the 'neglect' quadrant.
Therefore, whilst these findings do not support the theory that the Poor Me group has an early experience of relationships characterised by ‘neglect’, it does appear to be the case that the two groups can be differentiated along the ‘overprotection’ scale of the PBI.

**Hypothesis 2: threats to self-construction**

Hypothesis two stated that the Poor Me group would report greater vulnerability to insecurity threats, whereas the Bad Me group would be more vulnerable to alienation threats. This hypothesis was not supported. Although mean scores were different in the predicted direction, this study found no significant difference between the two groups on reported alienation or insecurity threats to self-construction.

**Hypotheses 3 and 4: current emotional experience**

As predicted, by hypotheses three and four, the Bad Me group reported considerably higher depression and shame scores than the Poor Me group.

Both groups were more depressed than a non-clinical sample, with the Poor Me group’s mean BDI score falling within the range of ‘mild’ depression, and the Bad Me group’s falling within the range of ‘severe’ depression. The Bad Me group’s mean shame score was also notably higher than that of the non-clinical group reported by Andrews et al. (2002). However, the Poor Me group’s mean shame score was similar to that of a non-clinical sample. This implies that the
Poor Me group's experience of shame is within normal limits, whilst that of the Bad Me group may be more pathological.

*Hypothesis 5: presentation of a 'false self'*

Hypothesis five stated that there would be no significant difference between the two groups on a measure of socially desirable responding. This was to control for the possibility that the Bad Me group was responding in what they perceive to be a socially desirable manner, and thus presenting a 'false self' in an attempt to hide a shameful 'bad' self. As predicted, there was no significant difference between the groups. This implies that observed differences between the two groups were not accounted for by the presentation of a 'false self'.

*Hypothesis 6: delusional content*

Hypothesis six stated that the Poor Me group would score more highly on the 'Grandiose Delusions' sub-scale of the SAPS. This hypothesis was supported.

**Summary of results**

In summary, several theoretical predictions based on Trower and Chadwick's (1995) model of the two types of paranoia were supported by the study. Firstly, the Bad Me group was found to report early relationships with care-givers characterised by greater over-intrusion than the Poor Me group. However, the hypothesis that the Poor Me group would report early relationships characterised
by neglect, and the hypothesis that each group would report greater vulnerability
to different types of threat to self-construction was not supported. The
hypothesis that the two groups would differ in terms of type of current emotional
experience was also supported, with the Bad Me group reporting more shame
and depression than the Poor Me group.

Finally, Poor Me paranoia was found to be associated with grandiose delusions,
which supports Trower and Chadwick’s idea of the Poor Me’s narcissistic,
undeveloped ideal self, which has not been subjugated through negative
construction by an ‘other’.

The relationship between dependent variables in each group

Correlates between variables were examined for each group separately in an
attempt to determine if a different pattern of relationships would be found in
each group. Interestingly it was discovered that many variables correlated within
the Poor Me group, but not the Bad Me group. Negative correlations within the
Poor Me group were found between the care and overprotection scales of the
PBI; reported care and alienation threats to self-construction; and the lie scale
and reported shame. Positive correlations were observed between depression and
overprotection; and between depression and shame.

Only one significant relationship between variables was found within the Bad
Me group, namely a positive correlation between overprotection and shame.
The observed difference between the two groups in terms of the patterns of relationships is quite striking. One explanation could be that the relatively small numbers in the Bad Me group might have prevented detection of the relationships between variables found to be correlated in the Poor Me group. However, this seems unlikely because significant relationships between variables in one group were in each case matched by a coefficient that did not approach significance in the other group. This would suggest that the two groups are in fact, in some way qualitatively different from one another. Indeed, the Poor Me group is much closer to a non-clinical population, where a correlation between shame and depression and care and overprotection is also found.

Finally, in the general population the two types of threat to self-construction have been found to be positively correlated (Dexter-Smith et al., 2003). However, this relationship was not observed for either group. A speculative explanation for this observation is that each group in this clinical sample was reporting disproportionately more of one type of threat than the other in comparison with the normal population.

**Interpretation of findings**

The current study provides evidence for the reliable distinction between what Trower and Chadwick (1995) call Poor Me and Bad Me paranoia. Furthermore, the findings of this study are broadly consistent with the theoretical assertion that there are phenomenological differences between the two types of paranoia, and
that these differences may have their basis in early primary relationships with care-givers. The only other study, to our knowledge, that has examined differences between the two types was carried out by Chadwick et al. (in press). This study also identified some significant differences between the two groups, including a higher level of reported depression in the Bad Me group than the Poor Me group.

One criticism of the Poor Me- Bad Me distinction is that those phenomological differences are just snap-shots of one paranoid process across different points in time. Bentall et al.’s (2001) attribution-self-representation model proposes that Poor Me paranoia serves to defend against the self as bad or flawed, yet at times, when this defence is weak, a Bad Me profile might emerge. However, the current study found that the two groups report a different experience of early relationships with their primary care-giver on the PBI. This measure has been shown to produce reliable and valid scores, with psychiatric status having little impact on the stability, accuracy and impartiality of participants’ accounts (Brewin et al., 1993). The literature consistently demonstrates a link between the quality of early relationships and core beliefs about the self and others (Beck 1967, Young 1994). Furthermore, it has been suggested that the nature of these beliefs may influence a person’s experience of persecutory delusions (Freeman et al. 2002). The finding that the two groups experience different types of early relationships is therefore consistent with the idea of some stable, dispositional tendency towards Bad Me paranoia, rather than this being transient, emerging only when the Poor Me defence is weak.
The current study did not identify significant differences in perceived threats to self-construction across the two groups, which, it could be argued, forms the crux of Trower and Chadwick's (1995) distinction between the two types of paranoia. Methodological short-comings that may have prevented detection of a difference are considered later. However, one interpretation is that it is overprotection, rather than threats to self-construction, that is a pathological component in early relationships, influencing self-construction in such a way that it prevents use of self-serving bias amongst those with Bad Me paranoia (see Figure 2).

This idea is supported by a number of findings. Firstly the Poor Me group's scores did not fall in the 'neglect' quadrant of the PBI, in that they still reported more overprotection in their early relationships than the norm. This is not consistent with the idea that those with paranoia have a history of, and become vulnerable to, insecurity threats to self-construction, where the self-presentation is neglected by an indifferent other.
Secondly, the Poor Me group is more similar to the normal population (who we know use the self-serving bias) in terms of which variables correlate, for example shame and depression; overprotection and care. This is in line with Chadwick et al.'s (in press) finding that the Poor Me group reported higher self-esteem than the Bad Me group, scores similar to a 'no pathology group', whereas the Bad Me group was reported to be similar to a depressed/ anxious group.
Furthermore, Chadwick et al. (in press) discovered a disruption of the normal correlation between self-esteem/evaluation and depression in the Poor Me group but not Bad Me group, which is consistent with the view that Poor Me paranoia protects self esteem (Bentall et al., 1994).

Thirdly, the Bad Me group has a different profile to the Poor Me group in terms of which variables correlate. In this case shame is correlated with overprotection but not depression. This disruption of the normal correlation between depression and shame, a correlation repeatedly demonstrated in the literature (Andrews et al., 2002), is quite striking. One possibility is that shame may be directly linked with early experience of an intrusive care-giver, and the core self value that arises from such a relationship, rather than with current depression state (as it is in the Poor Me group and normal population).

One interpretation would therefore be that depression in the Bad Me group is related to the belief that they deserve to be persecuted, whilst shame is more tied up with their beliefs about the self (see fig 2).

In this scenario, alienation threats might be expected to also be correlated with overprotection and shame because, conceptually, alienation threats and overprotection appear very similar. The fact that this correlation was not observed might reflect a sample size too small to detect this relationship. However, the sample was clearly large enough to detect some differences between the two groups, and it could be that the two concepts perhaps do not overlap, or that the SOS was perhaps not sensitive enough to detect early
relationships characterised by alienation threats to self-construction in this sample.

In conclusion, it could be that the difference in attribution style amongst people with persecutory delusions is linked with current mood state, and may even fluctuate to some extent. It could also be that persecutory beliefs serve to defend against depression in the Poor Me group. Indeed, the Bad Me group in the current study was much more depressed than the Poor Me group. In line with Bentall et al.’s (1994) theory, this study also found similarities between the Poor Me group and the normal population. However, it is speculatively suggested here that there is something about an early relationship characterised by over-intrusion that determines a propensity to experience ‘Bad Me’ paranoia. It could be that this type of experience is linked with the development of a shameful self concept, which the Bad Me group is unable to defend against by employing the self-serving bias used in the Poor Me group, and, to a lesser extent, the normal population. In line with Trower and Chadwick’s (1995) theory, it could be that the Bad Me group is motivated to conceal the ‘bad’ self, and, through cognitive biases linked with shameful beliefs about the self, others’ behaviour is perceived as critical and rightfully persecutory.

**Strengths and weaknesses of the study**

The current study attempted to control for other extraneous variables, an example being the Lie Scale to check that differences between the two groups could not be attributed to the presentation of a ‘false self’. In addition, the sample was well
matched with no significant differences in demographics, diagnosis or severity of persecutory delusions.

The study did not control for other psychotic symptoms, since a symptom-based approach was taken. However, it is possible that differences could be due to, for example, the presence or absence of other psychotic symptoms such as hallucinations, the chronicity of other psychotic symptoms or duration of illness. Similarly, differences between the two groups could be accounted for by other factors associated with early relationships characterised by over-intrusion, for example physical or sexual abuse. Finally, it could be that differences between the two groups are solely due to differences in depression. Indeed, the literature demonstrates that depressed groups do not make external attributions for negative events (Bentall et al., 1994). In other words they do not instigate the self-serving bias in the same way as the general population. However, if this was the case one might expect depressed and normal samples to also be differentiated along the ‘overprotection’ scale. In fact some evidence indicates that, whilst depressed groups often do report more overprotection in early care-giving relationships than non-clinical groups, depression is more strongly associated with low care scores on the PBI (Narita-Tomohiro et al. 2000; Patton et al. 2001; Sato-Tetsuya et al. 2000; Shah & Waller, 2000). Since the two groups in this study did not differ on reported levels of care, both reporting low levels, it does not seem to be the case that differences can be accounted for by depression alone.
The possibility that the accuracy and impartiality of participants' retrospective accounts of their early experience of relationships was influenced by current mood state must be considered. However, in a comprehensive meta-analysis of the literature, Brewin et al. (1993) conclude that there is little reason to link the reliability and validity of recall of past experience with psychiatric status or depressed mood. Plantes, Pursoff, Brennan and Parker (1988) administered the PBI and a measure of depression to depressed patients both before and one month after therapy. PBI scores remained stable despite a significant reduction in depression.

All measures used in the study had good reliability and validity. However, all measures were self-report, and some asked participants to give retrospective accounts. Whilst it has been demonstrated that people with psychosis can give reliable accounts, for example of their childhood (Drayton et al., 1998), it is possible that inaccurate information is obtained through asking participants to give their own accounts. Both groups also scored quite highly on the Lie Scale. This may indicate a tendency of the sample to exaggerate their positive qualities, or a carelessness in responding.

There are also limitations associated with a cross-sectional design. Here, in particular, it would be useful to do a follow-up, perhaps after six months. Not only would this provide information about the reliability of the data obtained, but it would also give insight into whether the two types of paranoia are in fact stable, or whether they are dynamic, fluctuating over time.
There are some problems associated with the sample. Firstly it is hard to establish the representativeness of the sample. It could be, for example, that those who refused to take part in the study had more severe persecutory delusions. Secondly, a larger sample size, particularly for the Bad Me group, might have been more sensitive to detect a significant difference on threats to self-construction. In addition, the SOS has not, to our knowledge, been used with this group previously. This makes it hard to determine what numbers would be required to detect a significant difference should one exist. However, it must be considered that the sample size was big enough to detect other differences between the groups. It is therefore possible that the predicted differences in threats was not present or was not detected by the SOS. Had the sample size been bigger it would have also been possible to carry out a regression, looking at the independent effects of each variable.

During the recruitment procedure it was noted that the incidence of Bad Me paranoia appeared a lot lower than that of Poor Me paranoia. This seems to be in line with other studies. Trower and Chadwick’s original 1995 paper notes that only three of the 11 individuals experiencing persecutory delusions fitted a Bad Me description. Similarly, Chadwick et al.’s (in press) recent study managed to recruit 36 in the Poor Me group, but only 14 in the Bad Me group. This could be explained in terms of each group’s behaviour. The Poor Me group is likely to want to bring their persecutors to justice. In terms of Trower and Chadwick’s (1995) theory, they are likely to seek out an ‘other’ to whom they can present their grandiose self. This may lead to them being, in a sense, more ‘visible’, more obviously paranoid, possibly even seen as more likely to pose a ‘threat to
others' and thus be held on a psychiatric ward. The Bad Me group on the other hand is depressed, and motivated to conceal their 'bad' self. This may result in social withdrawal, making this group less visible to mental health workers. Furthermore, because of the way they present, this group may be seen in community settings more frequently than inpatient wards.

Finally it seems important to comment on the categorisation procedure. It was noted in the method that it was difficult to categorise some participants as Bad Me or Poor Me, for example when a contradictory account was given. Where this was the case, the direction of the rating went towards what appeared to be the most firmly held belief, and good inter-rater reliability was achieved. The fact that some participants gave confused or contradictory accounts is to be expected, since the Bad Me group is theorised to be motivated to conceal their shameful 'bad' self. They are unlikely to reveal to a researcher, who they have just met, whether they believe they deserve punishment or not, as this is a sensitive issue that they are deeply ashamed of. It would be expected that some participants defensively deny what they perceive to be a shameful truth. This point is supported by the fact that, when asked whether they thought they deserved punishment, two participants in the current study reluctantly replied 'yes, but I don’t want to tell you why', and several replied 'no' initially, but, as rapport built, indicated that they clearly did believe they deserved the punishment they thought they were experiencing or were about to experience. Research therefore has to be sensitive when asking paranoid participants whether they believe they deserve punishment or not. Rapport must be built first, and the researcher may have to come back to the question, as was the case in the current
study. Research which involves asking the participants to respond outright to this question without consideration of these issues may produce unreliable data.

Since there has been little research done in this area, and since the current study has revealed some new findings, it is essential that the study be replicated. This would preferably occur with a larger sample size and suggested follow-ups at six and twelve months.

**Future work**

The importance of conducting a longitudinal study with these groups, and replicating the current study, has already been stressed. In addition it might be interesting to look at latent self-representations across the two groups. One way this could be done is with an emotional Stroop task, tapping shame and depression across the two groups. The findings of the current study would suggest that both groups would be expected to report covert depression, though the Poor Me group is able to defend against this at an overt level through exaggeration of the self-serving bias. However, it would be expected that the Bad Me group would score more highly than the Poor Me group on a measure of covert shame, possibly due to the type of early relationships they have experienced.

The difficulty of categorising the two types has been discussed. The development of a tool designed to assess paranoia type would therefore be useful in this area of research and clinical work. This study would suggest that a semi-
structured interview, emphasising the importance of sensitive rapport building and allowing for some open ended questions might be appropriate. Guidelines on interpretation of responses would need to stress the importance of a clear link between current persecutory beliefs and beliefs around deserved punishment if an individual is to be categorised as experiencing Bad Me paranoia. Two examples from the current study can be used to illustrate this point. One participant believed that their landlord had been slowly heating up her room until the floor melted and she burnt to death, and that the staff on the ward planned to do the same thing and poison her food because of the sins she thought she had committed (she had been disobedient to her mother and had an abortion several years ago). She was categorised as experiencing Bad Me paranoia. Another participant believed that the police and the Queen were out to kill him because of his race. He maintained that he didn’t think he deserved this to happen to him. He later said ‘I am not a nice man’, though he clearly did not link this belief with his current persecutory beliefs (the Queen and the police were not trying to kill him because he was ‘not a nice man’). He was categorised as experiencing Poor Me paranoia.

Professional implications

The main clinical implication arising from this study is the importance of considering the impact of early relationships on the clinical presentation of the Bad Me group. It could be that, through the experience of an accepting therapeutic relationship which is careful to allow the individual space for autonomy, some of the individuals beliefs about a shameful, bad self and critical
others can be addressed. This is in line with Young's (1994) schema-focused approach to 're-parenting'.

The current findings suggest that a more conventional approach to working cognitively with persecutory delusions in the Poor Me group might be more appropriate (see Chadwick, Birchwood and Trower, 1996). It is important to recognise however that this group also had an experience of low care in their early relationships, and that the impact of this on current presentation would need to be addressed. Working with this groups' negative core beliefs might be a later target, particularly with regard to relapse prevention. This work might happen alongside addressing dysfunctional means of managing self esteem (through exaggeration of the self-serving bias) in the Poor Me group.

In conclusion, it is suggested that persecutory delusions that superficially appear to be similar in nature, may in fact reflect different experiences of early relationships and different psychological profiles. The focus of clinical work and the nature of the therapeutic relationship should therefore be adapted accordingly.
References

Ainsworth, M. D. S., Bell, S. M. & Sayton, D. J. (1975), Infant-mother attachment and social development: socialisation as a product of reciprocal responsiveness to signals. In M. Richards (Eds.), *The integration of a child into a social world*. Cambridge: Cambridge University Press.


Appendices
Dear Clinician

Study Title: Early relationships and emotional experience in two types of paranoia.

We are currently conducting a study looking at the difference between patients experiencing different types of persecutory delusions: ‘Poor Me’ and ‘Bad Me’ paranoia.

I am writing to ask for your help in recruiting people currently experiencing ‘Bad Me’ paranoia. Here the individual feels rightfully punished or persecuted because of something that they have done, said or thought, or because they believe that in some way they are a ‘bad person’. They accept their punishment/ persecution and believe they are deserving of it. This is different from Poor Me paranoia, where the individual believes that punishment is undeserved and unjustified, that they have done nothing wrong.

The study is questionnaire based, takes around 40-60 minutes, and participants will be given £10 for the time they have given up to take part. The necessary ethical approval has been obtained.

I would be grateful if you could pass on the names of anyone you know of who might fit the ‘Bad Me’ paranoia criteria. If anyone does come to mind, please return the enclosed reply slip via internal mail to the above address, e-mail me or give me a call. They will then be sent/ given an information sheet and asked whether they would like to take part in the study. Please also feel free to contact me if you would like further information about the study.

Thank you for your help,
Yours Sincerely

Emma Morris
Trainee Clinical Psychologist, UCL.

Research contact within the trust:
Appendix 1

Reply Slip

Study Title: Early relationships and emotional experience in two types of paranoia.

Name of clinician: ____________________________

Potential Participants experiencing 'Bad Me' paranoia

<table>
<thead>
<tr>
<th>Name (and D.O.B if available)</th>
<th>Contact details (if available)</th>
<th>Ward/ Service (and consultant, if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Return to:

Emma Morris
Trainee Clinical Psychologist

E-mail:

Telephone Number:
Appendix 2

INFORMATION SHEET:

Study Title: Early relationships and emotional experience in two types of people.

Researcher: Emma Morris, Trainee Clinical Psychologist, Sub-Department of Clinical Health Psychology, University College London, Gower Street, London. WC1E 6BT.

Supervisor: Dr Emmanuelle Peters, Henry Wellcome Building, Institute of Psychiatry, De Crespigny Park, London. SE5 8AF. Telephone No:

Introduction:
This is a student research project that will look at the type of relationships different people had with their parents, the way they view themselves, and how they feel. We are trying to understand how these might link up with current ideas people have about others and the world. It is not connected with any treatment you may be having at the moment.

Procedure:
- You are invited to take part in this study. Participation is entirely voluntary. If you decide to take part you will be invited for an interview with Emma Morris at a time convenient with you.
- During this meeting you will be asked some questions and be given some questionnaires to fill out with the help of the researcher.
- The whole procedure takes 40 - 60 minutes on average, and can be done over the course of one or more meetings.
- If for any reason you wish to drop out of the study, you are welcome to do so at any point. You do not have to give the researcher a reason, and it will not affect the care you receive in the future.
- Occasionally some people find these sorts of questions upsetting or difficult to answer. If this happens in your case, feel free to end the session or take a break if you want to.

Confidentiality:
- All the information you give in the meeting will be kept solely by Emma Morris. Information will be written down, but your name will not appear on any of these records. Nobody will be able to identify you from the research when it is written up.
- None of your doctors, nurses, social workers or other health professionals will be have access to anything spoken about or written down during the meeting, unless the researcher becomes seriously concerned about your own or others safety. If this happens, the researcher will discuss it with you first.
- Because information disclosed in this study is confidential, it will not affect the treatment you receive.

What's in it for you?
- Some people find that taking part in this kind of research can provide interesting and useful information about what they are like as people. If you are interested, feedback based on the meeting, or the research project as a whole can be provided at a later date.
- This kind of research often helps in developing effective ways of working therapeutically with people in the future.
- You will be paid £10 at the end of the meeting for the time you have given up to take part in the study.

Any questions?
If you would like to find out more about this study before you participate, please ask the researcher directly, or leave a message for her on.
Appendix 3
ETHICAL COMMITTEE (RESEARCH)

17 September 2003

Prof D Hemsley
Dept of Psychology
Institute of Psychiatry

Dear Prof. Hemsley,

Re: Early relationships and emotional experience in two types of paranoia (016/03)

The Chair of the Ethical Committee (Research) has taken action to approve this study from an ethical point of view.

Please note that this approval is subject to confirmation by the full Committee when it meets on 17 October 2003. Initial approval is given for one year. This will be extended automatically only on completion of annual progress reports on the study when requested by the EC(R). Please note that as Principal Investigator you are responsible for ensuring these reports are sent to us.

Please note that projects which have not commenced within two years of original approval must be re-submitted to the EC(R).

Any serious adverse events which occur in connection with this study should be reported to the Committee using the attached form.

Please quote Study No. 016/03 in all future correspondence.

Yours sincerely,

Margaret M Chambers
Research Ethics Coordinator
15th March 2004

Emma Morris,
20A Heathfield Park,
Willesden Green,
London NW2 5JE.

Dear Emma,

03/176: Differences between two types of paranoia

Acting under delegated authority I write to acknowledge receipt of your letter dated 2nd March 2004 and the enclosed clarification requested by the LREC in our letter to you dated 1st March 2004. There is now no objection on ethical grounds to the proposed study. I am therefore happy to give you the favourable opinion of the LREC:

Paperwork reviewed
LREC application form
Protocol
Patient Consent form
Patient Information sheet
GP/Consultant Information sheet
CV of lead researcher
Finalised questionnaire

Please note that this opinion alone does not entitle you to begin research

The Barnet, Enfield & Haringey LREC considers the ethics of proposed research projects and provides advice to NHS bodies under the auspices of which the research is intended to take place. It is the NHS body, which has the responsibility to decide whether or not the project should go ahead, taking into account the ethical advice of the LREC. Where these procedures take place on NHS premises or using NHS patients, the researcher must obtain the agreement of local NHS management who will need to be assured that the researcher holds an appropriate NHS contract and that indemnity issues have been adequately addressed.

The following conditions apply to this project

- The LREC will require a copy of the final report on completion of the project and require details of the progress of the project periodically (i.e. annually for longer projects)
The committee must receive immediate notification of any adverse or unforeseen circumstances arising out of the project.

If data is 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 Act 1998. Please consult your department data protection officer for advice.

Failure to adhere to these conditions set out above will result in the invalidation of this letter of no objection.

I confirm that LRECs are fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) guidelines as they relate to the responsibilities, composition, function operations and records of an Independent Ethics Committee/Independent Review Board.

Please forward any additional information/amendments regarding your study to the LREC Co-ordinator at the above address.

Your application has been given a unique reference number 03/176 please use it on all correspondence with the LREC.

Yours sincerely

Alison O'Kane
LREC Co-ordinator
Barnet, Enfield & Haringey
Appendix 4
DELUSIONS

Delusions represent an abnormality in content of thought. They are false beliefs that cannot be explained on the basis of the subject's cultural background. Although delusions are sometimes defined as "fixed false beliefs," in their mildest form delusions may persist only for weeks to months, and the subject may question his beliefs or doubt them. The subject's behavior may or may not be influenced by his delusions. The rating of severity of individual delusions and of the global severity of delusional thinking should take into account their persistence, their complexity, the extent to which the subject acts on them, the extent to which the subject doubts them, and the extent to which the beliefs deviate from those that normal people might have. For each positive rating, specific examples should be noted in the margin.

Persecutory Delusions
People suffering from persecutory delusions believe that they are being conspired against or persecuted in some way. Common manifestations include the belief that one is being followed, that one's mail is being opened, that one's room or office is bugged, that the telephone is tapped, or that police, government officials, neighbors, or fellow workers are harassing the subject. Persecutory delusions are sometimes relatively isolated or fragmented; but sometimes the subject has a complex set of delusions involving both a wide range of forms of persecution and a belief that there is a well-designed conspiracy behind them. For example, a subject may believe that his house is bugged and that he is being followed because the government wrongly considers him a secret agent for a foreign government; this delusion may be so complex that it explains almost everything that happens to him. The ratings of severity should be based on duration and complexity.

None

Questionable

Mild: Delusional beliefs are simple and may be of several different types; subject may question them occasionally

Moderate: Clear, consistent delusion that is firmly held

Marked: Consistent, firmly-held delusion that the subject acts on

Severe: Complex well-formed delusion that the subject acts on and that preoccupies him a great deal of the time; some aspects of the delusion or his reaction may seem quite bizarre

Have people been bothering you in any way?

Have you felt that people are against you?

Has anyone been trying to harm you in any way?

Has anyone been watching or monitoring you?

---

6
Delusions of Jealousy
The subject believes that his/her mate is having an affair with someone. Miscellaneous bits of information are construed as "evidence". The person usually goes to great effort to prove the existence of the affair, searching for hair in the bedclothes, the odor of shaving lotion or smoke on clothing, or receipts or checks indicating a gift has been bought for the lover. Elaborate plans are often made in order to trap the two together.

Have you ever worried that your husband (wife) might be unfaithful to you?

What evidence do you have?

Delusions of Sin or Guilt
The subject believes that he has committed some terrible sin or done something unforgivable. Sometimes the subject is excessively or inappropriately preoccupied with things he did wrong as a child, such as masturbating. Sometimes the subject feels responsible for causing some disastrous event, such as a fire or accident, with which he in fact has no connection. Sometimes these delusions may have a religious flavor, involving the belief that the sin is unpardonable and that the subject will suffer eternal punishment from God. Sometimes the subject simply believes that he deserves punishment by society. The subject may spend a good deal of time confessing these sins to whomever will listen.

Have you ever felt that you have done some terrible thing that you deserve to be punished for?

---

None

Questionable

Mild: Delusion clearly present, but the subject may question it occasionally

Moderate: Clear, consistent delusion that is firmly held

Marked: Consistent, firmly-held delusion that the subject acts on

Severe: Complex, well-formed delusion that the subject acts on and that preoccupies him a great deal of the time; some aspects of the delusion or his reaction may seem quite bizarre

---

Mild: Delusional beliefs may be simple and may be of several different types; subject may question them occasionally

Moderate: Clear, consistent delusion that is firmly held

Marked: Consistent, firmly-held delusion that the subject acts on

Severe: Complex, well-formed delusion that the subject acts on and that preoccupies him a great deal of the time; some aspects of the delusion or his reaction may seem quite bizarre

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**Grandiose Delusions**
The subject believes that he has special powers or abilities. He may think he is actually some famous personage, such as a rock star, Napoleon, or Christ. He may believe he is writing some definitive book, composing a great piece of music, or developing some wonderful new invention. The subject is often suspicious that someone is trying to steal his ideas, and he may become quite irritable if his ideas are doubted.

- Do you have any special or unusual abilities or talents?
- Do you feel you are going to achieve great things?

**Religious Delusions**
The subject is preoccupied with false beliefs of a religious nature. Sometimes these exist within the context of a conventional religious system, such as beliefs about the Second Coming, the Antichrist, or possession by the Devil. At other times, they may involve an entirely new religious system or a pastiche of beliefs from a variety of religions, particularly Eastern religions, such as ideas about reincarnation or Nirvana. Religious delusions may be combined with grandiose delusions (if the subject considers himself a religious leader), delusions of guilt, or delusions of being controlled. Religious delusions must be outside the range considered normal for the subject's cultural and religious background.

- Are you a religious person?
- Have you had any unusual religious experiences?
- What was your religious training as a child?

---

None 0
Questionable 1
Mild: Delusional beliefs may be simple and may be of several different types; subject may question them occasionally 2
Moderate: Clear, consistent delusion that is firmly held 3
Marked: Consistent, firmly-held delusion that the subject acts on 4
Severe: Complex, well-formed delusion that the subject acts on and that preoccupies him a great deal of the time; some aspects of the delusion or his reaction may seem quite bizarre 5
Somatic Delusions
The subject believes that somehow his body is diseased, abnormal, or changed. For example, he may believe that his stomach or brain is rotting, that his hands or penis have become enlarged, or that his facial features are unusual (dysmorphophobia). Sometimes somatic delusions are accompanied by tactile or other hallucinations, and when this occurs, both should be rated. (For example, the subject believes that he has ball bearings rolling around in his head, placed there by a dentist who filled his teeth, and can actually hear them clanking against one another.)

Is there anything wrong with your body?
Have you noticed any change in your appearance?

Ideas and Delusions of Reference
The subject believes that insignificant remarks, statements, or events refer to him or have some special meaning for him. For example, the subject walks into a room, sees people laughing, and suspects that they were just talking about him and laughing at him. Sometimes items read in the paper, heard on the radio, or seen on television are considered to be special messages to the subject. In the case of ideas of reference, the subject is suspicious, but recognizes his idea is erroneous. When the subject actually believes that the statements or events refer to him, then this is considered a delusion of reference.

Have you ever walked into a room and thought people were talking about you or laughing at you?
Have you seen things in magazines or on TV that seem to refer to you or contain a special message for you?
Have people communicated with you in any unusual ways?
Delusions of Being Controlled
The subject has a subjective experience that his feelings or actions are controlled by some outside force. The central requirement for this type of delusion is an actual strong subjective experience of being controlled. It does not include simple beliefs or ideas, such as that the subject is acting as an agent of God or that friends or parents are trying to coerce him to do something. Rather, the subject must describe, for example, that his body has been occupied by some alien force that is making it move in peculiar ways, or that messages are being sent to his brain by radio waves and causing him to experience particular feelings that he recognizes are not his own.

Have you ever felt you were being controlled by some outside force?

Delusions of Mind Reading
The subject believes that people can read his mind or know his thoughts. This is different than thought broadcasting (see below) in that it is a belief without a percept. That is, the subject subjectively experiences and recognizes that others know his thoughts, but he does not think that they can be heard out loud.

Have you ever had the feeling that people could read your mind?

<table>
<thead>
<tr>
<th>None</th>
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<tbody>
<tr>
<td>Questionable</td>
<td>1</td>
</tr>
<tr>
<td>Mild: Subject has experienced being controlled, but doubts it occasionally</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Clear experience of control, which has occurred on two or three occasions in a week</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Clear experience of control, which occurs frequently; behavior may be affected</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Clear experience of control which occurs frequently, pervades the subject's life, and often affects his behavior</td>
<td>5</td>
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</table>

<table>
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<th>None</th>
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</thead>
<tbody>
<tr>
<td>Questionable</td>
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</tr>
<tr>
<td>Mild: Subject has experienced mind reading, but doubts it occasionally</td>
<td>2</td>
</tr>
<tr>
<td>Moderate: Clear experience of mind reading which has occurred on two or three occasions in a week</td>
<td>3</td>
</tr>
<tr>
<td>Marked: Clear experience of mind reading which occurs frequently</td>
<td>4</td>
</tr>
<tr>
<td>Severe: Clear experience of mind reading which occurs frequently, pervades the subject's life, and often affects his behavior</td>
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### Thought Broadcasting

The subject believes that his thoughts are broadcast so that he or others can hear them. Sometimes the subject experiences his thoughts as a voice outside his head; this is an auditory hallucination as well as a delusion. Sometimes the subject feels his thoughts are being broadcast although he cannot hear them himself. Sometimes he believes that his thoughts are picked up by a microphone and broadcast on the radio or television.

Have you ever heard your own thoughts out loud, as if they were a voice outside your head?  
Have you ever felt your thoughts were broadcast so other people could hear them?

<table>
<thead>
<tr>
<th>None</th>
<th>Questionable</th>
<th>Mild: Subject has experienced thought broadcasting, but doubts it occasionally</th>
<th>Moderate: Clear experience of thought broadcasting which has occurred on two or three occasions in a week</th>
<th>Marked: Clear experience of thought broadcasting which occurs frequently</th>
<th>Severe: Clear experience of thought broadcasting which occurs frequently, pervades the subject's life, and often affects his behavior</th>
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<td>1</td>
<td>2</td>
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### Thought Insertion

The subject believes that thoughts that are not his own have been inserted into his mind. For example, the subject may believe that a neighbor is practicing voodoo and planting alien sexual thoughts in his mind. This symptom should not be confused with experiencing unpleasant thoughts that the subject recognizes as his own, such as delusions of persecution or guilt.

Have you ever felt that thoughts were being put into your head by some outside force?  
Have you ever experienced thoughts that didn't seem to be your own?

<table>
<thead>
<tr>
<th>None</th>
<th>Questionable</th>
<th>Mild: Subject has experienced thought insertion, but doubts it occasionally</th>
<th>Moderate: Clear experience of thought insertion which has occurred on two or three occasions in a week</th>
<th>Marked: Clear experience of thought insertion which occurs frequently</th>
<th>Severe: Thought insertion which occurs frequently, pervades the subject's life and affects behavior</th>
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### Thought Withdrawal

The subject believes that thoughts have been taken away from his mind. He is able to describe a subjective experience of beginning a thought and then suddenly having it removed by some outside force. This symptom does not include the mere subjective recognition of alogia.

Have you ever felt your thoughts were taken away by some outside force?

<table>
<thead>
<tr>
<th>None</th>
<th>Questionable</th>
<th>Mild: Subject has experienced thought withdrawal, but doubts it occasionally</th>
<th>Moderate: Clear experience of thought withdrawal which has occurred on two or three occasions in a week</th>
<th>Marked: Clear experience of thought withdrawal which occurs frequently</th>
<th>Severe: Clear experience of thought withdrawal which occurs frequently, pervades the subject's life and often affects his behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Global Rating of Severity of Delusions

The global rating should be based on duration and persistence of delusions, the extent of the subject's preoccupation with the delusions, his degree of conviction, and their effect on his actions. Also consider the extent to which the delusions might be considered bizarre or unusual. Delusions not mentioned above should be included in this rating.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Questionable</td>
<td>Delusion definitely present but, at times, the subject questions the belief</td>
</tr>
<tr>
<td>Mild:</td>
<td>The subject is convinced of the belief, but it may occur infrequently and have little effect on his behavior</td>
</tr>
<tr>
<td>Moderate:</td>
<td>The delusion is firmly held; it occurs frequently and affects the subject's behavior</td>
</tr>
<tr>
<td>Marked:</td>
<td>Delusions are complex, well-formed, and pervasive; they are firmly held and have a major effect on the subject's behavior; they may be somewhat bizarre or unusual</td>
</tr>
<tr>
<td>Severe:</td>
<td>Subject's appearance or apparel are very fantastic or bizarre</td>
</tr>
</tbody>
</table>

**BIZARRE BEHAVIOR**

The subject's behavior is unusual, bizarre, or fantastic. For example, the subject may urinate in a sugar bowl, paint the two halves of his body different colors, or kill a litter of pigs by smashing their heads against a wall. The information for this item will sometimes come from the subject, sometimes from other sources, and sometimes from direct observation. Bizarre behavior due to the immediate effects of alcohol or drugs should be excluded. As always, social and cultural norms must be considered in making the ratings, and detailed examples should be elicited and noted.

**Clothing and Appearance**

The subject dresses in an unusual manner or does other strange things to alter his appearance. For example, he may shave off all his hair or paint parts of his body different colors. His clothing may be quite unusual; for example, he may choose to wear some outfit that appears generally inappropriate and unacceptable, such as a baseball cap backwards with rubber galoshes and long underwear covered by denim overalls. He may dress in a fantastic costume representing some historical personage or a man from outer space. He may wear clothing completely inappropriate to the climatic conditions, such as heavy wools in the midst of summer.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Questionable</td>
<td>Occasional oddities of dress or appearance</td>
</tr>
<tr>
<td>Mild:</td>
<td>Appearance or apparel are clearly unusual and would attract attention</td>
</tr>
<tr>
<td>Moderate:</td>
<td>Appearance or apparel are markedly odd</td>
</tr>
<tr>
<td>Marked:</td>
<td>Subject's appearance or apparel are very fantastic or bizarre</td>
</tr>
</tbody>
</table>

Has anyone made comments about your appearance?
Appendix 5

Participant No. Date

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

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

Participant No. Date

ESS: Everybody at times can feel embarrassed, self-conscious or ashamed. Some of these questions are about such feelings if they have occurred at any time in the past year. There are no "right" or "wrong" answers. The first set of responses are divided into 4 options, the second set are just 'yes' or 'no'. For each question please indicate the response that applies to you with a cross.

<table>
<thead>
<tr>
<th>Part One.</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you felt ashamed of any of your personal habits?</td>
<td></td>
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<td></td>
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<tr>
<td>2. Have you worried about what other people think of any of your personal habits?</td>
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<tr>
<td>3. Have you tried to cover up or conceal any of your personal habits?</td>
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<tr>
<td>4. Have you felt ashamed of your manner with others?</td>
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<tr>
<td>5. Have you worried about what other people think about your manner with others?</td>
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<tr>
<td>6. Have you avoided people because of your manner?</td>
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<tr>
<td>7. Have you felt ashamed of the sort of person you are?</td>
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<tr>
<td>8. Have you worried about what other people think of the sort of person you are?</td>
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<tr>
<td>9. Have you tried to conceal from others the sort of person you are?</td>
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<tr>
<td>10. Have you felt ashamed of your ability to do things?</td>
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<tr>
<td>11. Have you worried about what other people think of your ability to do things?</td>
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</tr>
<tr>
<td>12. Have you avoided people because of your inability to do things?</td>
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<tr>
<td>13. Do you feel ashamed when you do something wrong?</td>
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<tr>
<td>14. Have you worried about what other people think of you when you do something wrong?</td>
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<tr>
<td>15. Have you tried to cover up or conceal things you have felt ashamed of having done?</td>
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<tr>
<td>16. Have you felt ashamed when you said something stupid?</td>
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<tr>
<td></td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Very Much</td>
</tr>
<tr>
<td>---</td>
<td>------------</td>
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<td>------------</td>
<td>-----------</td>
</tr>
<tr>
<td>17. Have you worried about what other people think when you have said something stupid?</td>
<td></td>
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<tr>
<td>18. Have you avoided contact with anyone who knew you said something stupid?</td>
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<tr>
<td>19. Have you felt ashamed when you have failed at something important to you?</td>
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<tr>
<td>20. Have you worried about what other people think of you when you fail?</td>
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<td></td>
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<tr>
<td>21. Have you avoided people who have seen you fail?</td>
<td></td>
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</tr>
<tr>
<td>22. Have you felt ashamed of your body or any part of it?</td>
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<td></td>
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</tr>
<tr>
<td>23. Have you worried what other people think of your appearance?</td>
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<tr>
<td>24. Have you avoided looking at yourself in the mirror?</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>25. Have you wanted to hide or conceal your body or any part of it?</td>
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</tbody>
</table>
Appendix 7

Participant No. | Date
---|---

**Self and Other Scale:** Below are some questions about you and how you feel about other people. Please rate each item by placing a cross in the most appropriate box.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree slightly</th>
<th>Unsure</th>
<th>Disagree slightly</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Having a secure relationship helps me feel I exist</td>
<td></td>
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</tr>
<tr>
<td>2. When I am alone I feel the need to contact someone</td>
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</tr>
<tr>
<td>3. I have to be close to someone to have a sense of who I am</td>
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<tr>
<td>4. I am nothing without certain special other people</td>
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<tr>
<td>5. Sometimes when I am alone I have a strange feeling that I am not real</td>
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</tr>
<tr>
<td>6. If I am not getting the right kind of attention it's like I'm not there</td>
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<tr>
<td>7. Special people are vital to my sense of being a person</td>
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<tr>
<td>8. I dread being under someone else's control</td>
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</tr>
<tr>
<td>9. I have to get away from other people in order to have a sense of who I am</td>
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<tr>
<td>10. If I get too much attention it can feel like I'm being taken over</td>
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<tr>
<td>11. I’d hate certain people to know the real me</td>
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<tr>
<td>12. Often I wish people would give me space to be myself</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>13. Sometimes I only feel like me when I am on my own</td>
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<td></td>
</tr>
<tr>
<td>14. I can feel suffocated if I am too close to someone</td>
<td></td>
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</tbody>
</table>
### Appendix 8

<table>
<thead>
<tr>
<th>Participant no.</th>
<th>Date</th>
</tr>
</thead>
</table>

(LS) Please answer ‘yes’ or ‘no’ for each question by placing a tick in the box.

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. Have you ever taken praise for something you knew someone else had really done?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Were you ever greedy by helping yourself to more than your share of anything?</td>
<td></td>
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<tr>
<td>28. If you say you will do something, do you always keep your promise no matter how inconvenient it might be?</td>
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<td></td>
</tr>
<tr>
<td>29. Have you ever blamed someone for doing something you knew was really your fault?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Are all your habits good and desirable ones?</td>
<td></td>
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<tr>
<td>31. Have you ever taken anything (even a pin or a button) that belonged to someone else?</td>
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</tr>
<tr>
<td>32. Do you sometimes talk about things you know nothing about?</td>
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<tr>
<td>33. As a child did you do as you were told immediately and without grumbling?</td>
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<tr>
<td>34. Have you ever broken or lost something that belonged to someone else?</td>
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<tr>
<td>35. Do you sometimes boast a little?</td>
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<tr>
<td>36. Have you ever said anything bad or nasty about anyone?</td>
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<td></td>
</tr>
<tr>
<td>37. As a child were you ever cheeky to your parents?</td>
<td></td>
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<tr>
<td>38. Have you ever cheated at a game?</td>
<td></td>
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<tr>
<td>39. Have you ever taken advantage of someone?</td>
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<tr>
<td>40. Would you dodge paying taxes if you were sure you would never be found out?</td>
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<tr>
<td>41. Have you ever insisted on having your own way?</td>
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<tr>
<td>42. Do you always practice what you preach?</td>
<td></td>
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<tr>
<td>43. Have you ever been late for an appointment or work?</td>
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<tr>
<td>44. Do you sometimes put off until tomorrow what you ought to do today?</td>
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<tr>
<td>45. Are you always willing to admit it when you have made a mistake?</td>
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</tbody>
</table>