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The Fear of Others: A Qualitative Analysis of Interpersonal Threat in Social Phobia and Paranoia

Luisa Stopa, Ruth Denton and Megan Wingfield

University of Southampton, UK

Katherine Newman Taylor

Southern Health NHS Foundation Trust, and University of Southampton, UK

Background and Aims: The cognitive models indicate that people with social phobia and paranoia share a common fear of others. While we recognize clinical differences, it is likely that some of the same psychological processes contribute to the maintenance of both presentations, yet the nature and extent of these similarities and differences are not yet clearly understood. This study explored threat experiences in people with social phobia and persecutory delusions in order to elucidate these aspects of the respective cognitive models. **Method:** Accounts of interpersonal threat experiences were examined in nine people with social phobia and nine people with persecutory delusions. Verbatim transcripts were analyzed using thematic analysis. **Results:** Three major themes emerged from the data: participants' experience of threat, reactions while under threat, and subsequent reflections. Narrative coherence emerged as a superordinate theme. Typical fear responses were found in both groups, particularly in their reactions to threat. The key differences were in participants' perceptual experiences, ability to stand back from the threat following the event, and narrative coherence. **Conclusions:** The findings are discussed in relation to current cognitive models of social phobia and paranoia. Theoretical and clinical implications are drawn out, and highlight the need to examine attentional and metacognitive processes more closely if we are to understand the maintenance of perceived threat in these groups, and means of alleviating associated distress.

Keywords: Social anxiety, paranoia, cognitive model, qualitative methods.

Introduction

The current cognitive models indicate that interpersonal threat beliefs are a key component of both social phobia (Clark and Wells, 1995; Rapee and Heimberg, 1997) and paranoia (Bentall, Corcoran, Howard, Blackwood and Kinderman, 2001; Bentall, Kinderman and Kaney, 1994; Freeman and Garety, 2000; Freeman, Garety, Kuipers, Fowler and Bebbington, 2002; Gumley and Schwannauer, 2006; Trower and Chadwick, 1995). Social phobia is the fourth most

Reprint requests to Katherine Newman Taylor, School of Psychology, University of Southampton, Southampton SO14 1BJ, UK. E-mail: knt@soton.ac.uk

common psychiatric disorder (Kessler et al., 2005). The presentation is characterized by a fear of humiliating or embarrassing the self in social situations; in other words an intense fear of negative evaluation, leading to anxiety and avoidance of social situations (Clark and Wells, 1995). Paranoia refers to beliefs ranging from social evaluative concerns through to persecutory delusions in which the person fears intended physical, social or psychological harm to themselves (Freeman and Garety, 2000; Freeman et al., 2005). A key difference in the cognitive models, then, is the distinction between negative evaluation and intended harm. Although this is quite clear in theory, this is not always the case in clinical settings, for example in conceptualizing pervasive fears that go beyond negative evaluation to beliefs that others are bullying or humiliating the person.

In addition to the overlap in the content of threat beliefs, it is likely that similar psychological processes contribute to the maintenance of social phobia and paranoia (see Freeman et al., 2002, following Clark, 1999). This is supported indirectly by the co-morbidity literature in which social phobia has repeatedly been identified as a risk factor for a diagnosis of schizophrenia spectrum disorders (Cossoff and Hafner, 1998; Michail and Birchwood, 2009; Olin and Mednick, 1996).

Despite similarities in the content of cognition, and evidence of an epidemiological relationship, we know clinically that we can usually distinguish these presentations. However, the nature and extent of the similarities and differences between the two are not yet fully understood in psychological terms. This is important because cognitive behavioural interventions depend on clear and accurate formulation of the experience and maintenance of distress, and so a detailed understanding of these processes is essential to effective therapeutic work. This study examines the lived experience of people with social phobia and people with persecutory delusions in feared situations in order to elucidate the experience of interpersonal threat in each group.

Problems of interpersonal threat: the cognitive models of social phobia and paranoia

Current cognitive models assume that people with social phobia hold beliefs about the self as flawed (e.g. "I'm weird," "I'm odd", "I don't fit in" and "I'm not like other people") which are activated in social situations, and trigger anxiety (Clark and Wells, 1995; Hofmann, 2007; Rapee and Heimberg, 1997). Clark and Wells (1995) emphasize unrealistic standards for social performance, for example "I must look completely confident at all times", as well as catastrophic beliefs about failing to achieve these expectations such as "they won't want to know me". Once these beliefs and assumptions have been activated, a series of inter-linked psychological processes maintain the anxiety, including streams of automatic thoughts about performance and the self (e.g. Norton and Hope, 2001, Rapee and Lim, 1992; Stopa and Clark, 1993), avoidance and safety behaviours that prevent disconfirmation of beliefs, and interpretational (Amir, Foa and Coles, 1998; Stopa and Clark, 2000) and attentional processes (Amir, Freshman and Foa, 2002; Pishyar, Harris and Menzies, 2004; Spector, Pecknold and Libman, 2003). The Clark and Wells model emphasizes the central role of self-focused attention leading to intense self-consciousness, resulting in the individual focusing on the content of consciousness in which the feared representation of self is often manifest as an image of the person seen from an observer perspective (Hackmann, Surawy and Clark, 1998; Hackmann, Clark and McManus, 2000), for example shaking violently or stuttering uncontrollably. This image, based on subjective feelings of anxiety, maintains

the fear of negative judgments by other people because the person assumes that this is what other people actually see. The internal focus on the self may also be linked to characteristic patterns of behaviour in social phobia such as avoidance of eye contact (Horley, Williams, Gonsalvez and Gordon, 2004), which may represent a strategy aimed at preventing other people from noticing, and therefore negatively evaluating the individual. However, this attentional strategy is counter-productive because it prevents individuals from obtaining data that might disconfirm their beliefs about other people's negative judgments.

Cognitive models of paranoia (Bentall et al., 2001, 1994; Freeman et al., 2002; Trower and Chadwick, 1995) also assume that problematic core beliefs about the self (that may or may not reach conscious awareness, following Trower and Chadwick, 1995), and about others, contribute to an enduring vulnerability to paranoia (Fowler et al., 2006; Moorhead, Samarasekera and Turkington, 2005; Rector, 2004).

In arguably the best evidenced of these models, Freeman et al. (2002) propose that for vulnerable individuals, stressful situations trigger arousal and generate anomalous cognitive experiences, such as thoughts being heard as voices and actions experienced as unintended. The paranoid belief is reached as an attempt to make sense of these experiences. As in social phobia, cognitive biases and behavioural responses then maintain the belief through a combination of confirmatory and disconfirmatory processes (following Clark, 1999). These include anxiety driven avoidance and other safety behaviours (Freeman, Garety and Kuipers, 2001), selective attention (Bentall, Kaney and Bowen-Jones, 1995; Fear, Sharp and Healy, 1996) and interpretational biases (Bentall, Kaney and Dewey, 1991; Frith, 1992; Garety, Hemsley and Wessely, 1991).

A hierarchy of interpersonal threat beliefs

Perhaps the clearest account of the range of interpersonal threat beliefs is described in the hierarchy of paranoia developed by Freeman and colleagues. These authors propose five levels of threat associated with increasing distress and disability: (i) social evaluative concerns (e.g. fears of negative evaluation or rejection); (ii) ideas of reference (e.g. people talking about you); and (iii) mild (e.g. people trying to irritate you); (iv) moderate (e.g. people going out of their way to get at you); and (v) severe threat beliefs (e.g. people trying to cause you significant harm) (Freeman et al., 2005). Consistent with the continuum model of psychosis (e.g. Combs and Penn, 2004; Johns et al., 2004, Johns and van Os, 2001), this hierarchy spans beliefs characteristic of social anxiety through to persecutory delusions, and assumes that these delusions build on more common evaluative beliefs and ideas of reference likely to be associated with social phobia.

This study investigates the lived experience of threat beliefs in social phobia and persecutory delusions. In addition to the content of fears, we examined people's responses to being under threat both at the time and in hindsight. This included an assessment of individuals' metacognitive awareness of interpersonal threats, given the increasing recognition of the importance of being able to stand back or "decentre" from internal experience in mental health (see Teasdale et al., 2002; Wells, 2000).

Aims

This research examined the experience of being under threat in social phobia and paranoia. It is likely that similar psychological processes maintain interpersonal threat beliefs in both

Table 1. Participant demographics

Participant	Group	Age	Gender	Marital Status	Treatment Status	Employment
5	Social phobia	54	Male	Divorced	Outpatient	Unemployed
6	Social phobia	31	Female	Married	No current treatment	Employed
7	Social phobia	22	Female	Single	No current treatment	Unemployed
8	Social phobia	26	Female	Single	No current treatment	Employed
9	Social phobia	20	Male	Single	No current treatment	Unemployed
10	Social phobia	26	Female	Single	Outpatient	Employed
12	Social phobia	49	Female	Married	Outpatient	Unemployed
13	Social phobia	58	Female	Divorced	No current treatment	Employed
14	Social phobia	24	Female	Single	No current treatment	Sick leave
1	Paranoia	29	Female	Single	Outpatient	Unknown
2	Paranoia	38	Female	Single	Outpatient	Unpaid work
3	Paranoia	50	Female	Married	Outpatient	Unemployed
4	Paranoia	29	Male	Single	Outpatient	Unemployed
11	Paranoia	38	Female	Married	Outpatient	Unemployed
15	Paranoia	57	Male	Single	Outpatient	Unemployed
16	Paranoia	44	Male	Single	Outpatient	Unemployed
17	Paranoia	52	Male	Divorced	Outpatient	Unemployed
18	Paranoia	34	Male	Single	No current treatment	Unemployed

presentations, yet the nature and extent of the similarities and differences between the two are not yet clearly understood.

This study aimed to contribute to the ongoing development of the respective clinical cognitive models by examining threat experiences in people with social phobia and persecutory delusions. A qualitative approach was used because the aim was to understand and represent individuals' experiences as they encounter, engage and live through these distressing situations in order to better understand the psychological processes involved (Elliott, Fischer and Rennie, 1999).

Method

Participants

Participants with social phobia and persecutory delusions were recruited to this research, and a linked study comparing these groups with clinical and non-clinical controls (Newman Taylor and Stopa, 2012). The Structured Clinical Interview for DSM-IV-TR Axis I disorders (First, Spitzer, Gibbons and Williams, 2001) was used to confirm DSM-IV diagnostic criteria. Thirteen people met criteria for social phobia and 13 met criteria for schizophrenia (but not social phobia), with persecutory delusions. Eight people then declined to be recorded during interview, leaving a total of 9 people in each group, 18 in total. Eight of the 9 people with social phobia had generalized type, one person had specific type (focused on just two situations). The SCID indicated no comorbidity in these18. Participants were not matched. Demographic characteristics are given in Table 1.

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Procedure

Participants were recruited through consultant psychiatrists on the basis of current diagnosis. These individuals were then contacted by telephone, given information about the research, and asked if they would like to participate. An assessment session was arranged at a hospital setting where participants were given written information about the study and asked to sign a consent form if willing to take part. The SCID overview (for patients) and modules (psychosis screen/modules B and C, mood episodes and anxiety disorders) were then completed to confirm diagnosis. Only the standard probes included in the SCID were used. The semi-structured interview was completed (along with questionnaires for the linked study) and audio-recorded for later analysis. All measures were administered by a clinical psychologist or psychology assistant. A clinical psychologist who was experienced in diagnosis and had experience of using the SCID in previous research studies trained the other clinical psychologist and psychology assistants. This included instruction in use of the SCID, observation of an experienced user, and then being observed in order to ensure effective use of the tool.

Interview

The Cognitive Profiling Interview (CPI; Wells, 2000) was adapted for the purpose of the present study. The CPI was developed to assess people's responses and metacognitive responses to distressing situations. Individuals are asked to describe a recent situation that causes distress and is typical of their difficulties. The interviewer then prompts participants to discuss the following aspects of their experience:

i) the nature of the distressing event;
ii) associated thoughts and feelings;
iii) focus of attention;
iv) reflections on the experience, looking back.

The interview consists of a standard set of questions and prompts. The semi-structured format allows participants to expand on questions if relevant. Interviews lasted between 20 and 60 minutes, and were recorded with participants' permission. The adapted measure is available on request.

Analysis

The interviews were transcribed verbatim and underwent a detailed qualitative analysis. The transcripts were analyzed following thematic methods (e.g. Braun and Clarke, 2006) in which researchers immerse themselves in the data – reading and rereading the transcripts several times to ensure familiarity and understanding. Through this process, key ideas emerged and were discussed rigorously within the research team producing initial codes. Codes identified across the data set were then honed into a clear set of prominent themes and subthemes. Following best practice guidelines for qualitative analysis (Elliott et al., 1999), this stage was supervised by another researcher to ensure clarity and consistency in themes elicited. The transcripts were then reread against the themes to ensure reliability. Any themes that did not appear frequently in the transcripts or among multiple participants were discarded. Themes

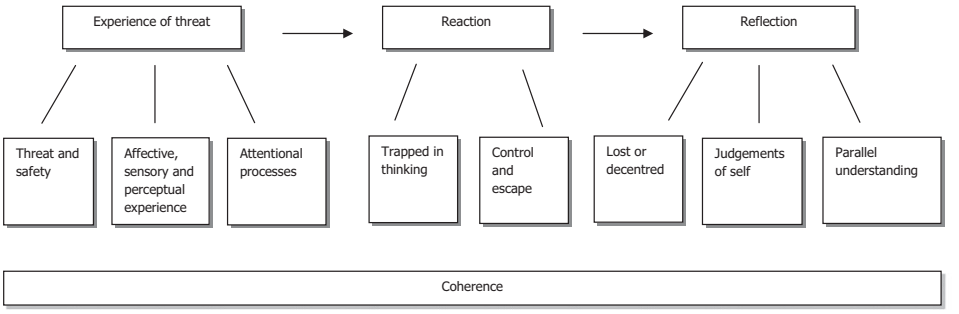

Figure 1. Themes and subthemes drawn from the qualitative analysis

were then named and defined. A full codebook was compiled and is available on request. The results were drawn from the codebook, and representative quotes illustrate each theme and subtheme.

Results

Three major themes were identified through the thematic analysis. Participants discussed their "experience of threat", their "reactions" at the time of the threat, and their "reflections" following the event or situation. Subthemes were identified within each major theme, and are defined and illustrated below. In addition, an overarching category of "coherence" emerged across the themes, reflecting the extent to which participants were able to communicate a cogent and broadly consistent account of their experiences (see Figure 1).

Experience of threat

This main theme comprises people's direct experiences of being under threat. This includes an acute awareness of threat and desire for safety (threat and safety); people's emotional, bodily and perceptual sensations (affective, sensory and perceptual experience); and attentional processes engaged while under threat (attentional processes).

Threat and safety. Participants described an acute awareness of current threat as a core component of their experience. This was evident in most interviews and differed between the social phobia and paranoia groups. People with social phobia reported a sense of imminent danger and an urgent need to get to safety, rather than focusing on the source of threat or feared consequences:

Researcher: Okay, okay so what's going through your mind is "I've gotta get home"?

Participant 5 (SP): Yeah . . . I'm safe there.

Participant 13 (SP): Yes I just can't think of anything I just want to go home, and sit on my own at home.

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By contrast, people with paranoia focused more on being targeted and victimized by others. For these participants the source of threat and feared consequences were highly salient and often elaborated:

> **Researcher:** And what did you, can you tell me more about this idea that people were coming at you?
>
> **Participant 3 (Para):** Well, it was just going outside and people were gonna be there waiting for me . . . and they're going to attack me and leave me sort of unconscious in the . . . on the road or try and run me off the road with a car.

For some, the perceived danger was not of physical harm but instead of damage to their reputation, or ridicule:

> **Participant 2 (Para):** I thought they were talking about me in the other room . . . I thought he was making plans to make me look stupid.

While all participants described their experience of being under threat, the desire to get to safety was most salient for people with social phobia, and those with paranoia focused more on the nature and consequences of the threat.

Affective, sensory and perceptual experience. Participants gave vivid descriptions of their emotional, physical and perceptual experiences at the time of threat. These included memories and images, as well as voices and visual hallucinations for people in the paranoia group. Participants' responses indicated a strong sense of being overwhelmed by their emotions:

> **Participant 12 (SP):** The fears, they just take over, over.
>
> **Participant 3 (Para):** I was just, I just felt totally terrified.

Individuals' emotional reactions were typical of anxiety and fear; people reported feeling "nervous" (Ppt. 5, SP), "anxious" (Ppt. 6, SP), "scared" (Ppt. 7, SP), "totally desperate" (Ppt. 3, Para) and "totally terrified" (Ppt. 3, Para). Similarly, both groups reported bodily sensations associated with intense anxiety; "physically, I was shaken, palpitations, sweat" (Ppt. 7, SP), "I'll start stuttering" (Ppt. 5, SP), "breathing might come rapid and shallow" (Ppt. 2, Para) and "can't breathe properly, feel suffocated" (Ppt. 3, Para).

Interestingly, there were differences in the quality of memories and images reported from the time of distress. People with social phobia often recalled particular memories that had elicited similar fears, and clearly recalled these as past events:

> **Researcher:** When you were thinking about the holiday did it bring up any memories?
>
> **Participant 6 (SP):** . . . of when I've been on holidays before and when I've had to go on school trips before, it all stems back to when I was small . . . I've never had a good memory of going out for the day or going on a holiday.

Many in the paranoia group also identified memories or images linked to the threat situation, but in contrast to the social phobia group, appeared to relive memories or experience the images as reactivated; these participants described what they were seeing and feeling in striking detail:

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Participant 11 (Para): Yeah, that's why I cut myself because I kinda, I started to see ropes round my wrists I started to see, if I tried to talk about anything I started to get the choking feeling . . . I cut my stomach 'cause I feel as though there's something there, sort of lying there . . . I just want to cut it away, get rid of it.

At times, it was unclear whether the person was describing vivid memories, images or hallucinatory experiences; at times the distinction seemed to be unclear to participants as well as the researchers.

Others in the paranoia group described images associated with delusional beliefs, for example Participant 16 who believed that his father was living on the streets, and that his ex-partner was being held and abused:

Researcher: And how vivid is the image that you've just described?

Participant 16 (Para): It usually, seems to be usually in black and white.

Researcher: Okay and that's both the image of your father on the street in a tatty coat did you say?

Participant 16 (Para): Yes.

Researcher: And the bikers around him, is that right?

Participant 16 (Para): Yeah.

Researcher: And the other is of Sarah on the cross and being raped by, by the bikers?

Participant 16 (Para): Yeah, yeah I had all those images, a bit like a movie in my mind, yeah bit like a, yeah.

The perceptual experiences for those with paranoia also included voices. Some voices gave advice, others issued commands in threatening situations. One woman heard voices when a number of boys were shouting and mocking her:

Participant 11 (Para): I start getting the voices and the voices coming on and they're telling me to harm him and do things to him.

Others were potentially comforting:

Participant 3 (Para): The voices were saying "don't worry", they were saying to me actually "don't worry she will get the time off", but I, I wouldn't even listening to them, I was so uptight in myself.

Participant 3 (Para): Well they, they let me know who, who to be on guard against so if I'm walking into Tesco's and somebody's coming at me, they'll say "it's alright, just keep walking, look straight past them he's gonna be alright" or "she'll be alright" or they'll say "be careful, there's a thing coming", you know somebody with a, a threat, they'll let me know.

Participant 17 described clear and distressing visual hallucinations in feared situations:

Participant 17 (Para): I was getting these hallucinations and these shadows and these frightening demonic thoughts and things, people turning into demons.

Participant 17 (Para): I think I mentioned that I was in the ward I saw all these, it wasn't just me that was evil, but I was like Satan, the lord of it all, but all the other patients were turning into white devils as well at the same time.

In summary, all participants gave vivid descriptions of their emotional and bodily sensations at the time of threat, and these were consistent with usual fear responses. The groups differed in their perceptual experiences. People with paranoia reported voices and visual images, and the distinction between memories and hallucinatory experiences was at times unclear.

Attentional processes. As part of the structured interview participants were asked to comment on attentional processes in feared situations. This subtheme encompasses participants' experiences of self-consciousness, focus of attention and perspective taking at the time of distress. Participants in both groups consistently reported feeling self-conscious when under threat. Interestingly, when asked what they were paying most attention to in the threat situation, participants focused both on themselves (as the object of threat), and on others (as the source of threat):

Participant 13 (SP): I was just overwhelmed actually. . .Overwhelmed by all these people, which of course I knew there were gonna be thousands of people anyways so, I it was no surprise really.

Participant 15 (Para): People in the streets.

Participant 7 (SP): Um, making sure I didn't make eye contact with anyone . . .

Participant 2 (Para): And trying to keep my shaking under control, use all my tricks with steady breathing, all that sort of thing.

In addition to self-consciousness and focus of attention, participants were asked about their perspective taking. In both groups, some participants reported experiences from an observer perspective (as if watching themselves from the outside), and others described events or memories from a field perspective (from behind their own eyes). Furthermore, those taking an observer perspective varied in terms of whether this was imagined from another individual's perspective or from a wider "bird's eye view", as if looking on the scene from above. Perhaps most interestingly, the perspective taken by participants from both groups often varied or switched between observer and field perspectives over periods of distress.

Two people in the paranoia group described possible dissociative processes when their distress was most intense. For example, Participant 3 described this process as if she existed in another place or time, which prevented her from being actively involved in what was happening:

Participant 3 (Para): I'm not aware I've done it, I'm not, I am aware I'm doing it, but I don't, it's like being in a different sort of time lock. I suddenly, I suddenly click back and think [sigh] "oh dear" . . .

In summary, participants' focus of attention was complex and varied over time. People in both groups reported strong feelings of self-consciousness. They focused both on the source of perceived danger and themselves as the object of threat. Many described both observer and field perspectives, with their perspective changing over time. Two of the paranoia group reported dissociating from the experience when most distressed.

Reaction

This second major theme incorporates participants' reactions to distressing situations or events, and includes the person's patterns of thinking, and the internal resources activated to manage their experience. This theme includes the subthemes of "trapped in thinking" and "control and escape".

Trapped in thinking. This theme describes participants' accounts of the intrusive, compelling and seemingly inescapable streams of thought experienced during times of distress. For many the threat triggered cyclical patterns of thinking in which they felt trapped and stuck:

> **Participant 8 (SP):** I can't stop thinking about it. It's like I can't shut off . . . I've got it on my mind all the time.

> **Participant 03 (Para):** . . . I'm just thinking about it constantly . . . I can't put my mind onto things I want to think about, I just think about that all the time.

> **Participant 3 (Para):** Umm, I just quite worry, I was anxious and I thought the bus driver was looking at me through the mirror to see I was, I was behaving, people around me were aware of it and um, I felt, I was being watched you know and the more I think I'm being watched the worse, the worse it gets.

Many also described feeling overwhelmed by the speed with which their thoughts came to mind:

> **Participant 10 (SP):** And I just get really like, thoughts just come into my head really, really quickly and I don't get time to order them at all.

> **Participant 2 (Para):** . . .your thoughts are racing. . .

Participants in both groups reported streams of thought that were intrusive and overwhelming, and a powerful sense of being trapped in these internal patterns.

Control and escape. Participants described a range of coping behaviours initiated in response to the threat, including attempts to avoid, escape or control the experience. People in both groups used behavioural and more subtle ways of removing themselves from threatening situations:

> **Researcher:** Okay, what did you want to do in the situation?

> **Participant 12 (SP):** Not to come. . .Just to cancel it all to avoid the situation.

> **Participant 5 (SP):** That's what I mean, I get home as quick as I can 'cause it's, it's, it's I don't know what might happen, as I said, I play it safe, for me.

> **Participant 03 (Para):** Uh, wear a pair of sunglasses and hide away.

> **Participant 7 (SP):** Yes, yeah I suppose it's like going into a shell, just I don't say anything, I don't do anything, I just remove myself from the situation.

For others, the only way to cope was to take medication:

Participant 15 (Para): . . .for example, only last week when I went to town and uh, went to B–town and um, in the end I went, I went somewhere quiet and took haloperidol to calm me down a bit.

Some managed to remain in the situation by using distraction or other coping skills:

Participant 14 (SP): I do a crossword or something just so that I'm thinking of other things, trying to take my mind off. . .

Participant 18 (Para): No, I tried to use all the skills I have to sort of um calm myself and be optimistic um and I was looking to the future and thinking well if I don't make it I can also go er on a later flight.

For all participants the perception of threat initiated behavioural or internal responses to manage their fears.

Reflection

The third major theme incorporates individuals' responses to being under intense threat, after the immediate danger has passed. Three sub-themes of "lost or decentred", "judgements of self" and "parallel understanding" emerged.

Lost or decentred. A clear distinction emerged between the groups in their ability to distance themselves from the experience of threat, following the event. Away from the perceived source of threat, most people with social phobia were able to "step back" from the experience, cope more effectively once more, and review recent appraisals of danger:

Participant 4 (SP): Umm, [sigh] once I'm out of the situation I um, tend to not let, not think about it, it's over and done with and, and just carry on with whatever's going on.

Participant 13 (SP): Yeah, looking back on it, but I'm looking back on it from a calm point of view, at the time it was awful and now it was ridiculous . . .

Researcher: . . . do you think it could possibly be a distortion?

Participant 8 (SP): Distortion definitely yeah, no I don't think he was thinking bad of me but that's just what's in my head.

The contrast with people with paranoia was striking. The majority of people in this group were unable to distance themselves from the experience of being under threat, and continued to report intense and overwhelming affect regarding the event, despite recognizing that it was no longer happening:

Researcher: So even though you're not in that situation, just thinking about it. . .

Participant 3 (Para): Looking back. . .

Researcher: Makes you feel very upset?

Participant 3 (Para): Yeah.

Participant 3 (Para): It is extremely overwhelming.

Researcher: Even looking back?

Participant 3 (Para): Yes, yeah.

Researcher: Mmm hmm, and now looking back do you accept those thoughts and judgements as facts based in reality, do they seem to be. . .

Participant 15 (Para): They're real, yeah they're real thoughts yeah.

Researcher: . . .do they still seem to overwhelm you?

Participant 14 (Para): They do but not as much as what they did at the time, but they still do.

Judgements of self. Self-criticism and perceived criticism from others was common when participants reflected on their experiences of threat. Participants in both groups became highly critical of themselves, describing themselves as "stupid" (Ppt. 6, SP; Ppt. 9, SP), "not normal" (Ppt. 8, SP), "pathetic" (Ppt. 10, SP), "quite inadequate" (Ppt. 2, Para) and "utterly evil" (Ppt. 17, Para). Most believed that others perceived them similarly: "just obviously thinking I wasn't normal" (Ppt. 8, SP), "like just proves everybody else right, that I am stupid" (Ppt. 2, Para); "I said 'hello', they just completely ignored me, or they um, give me a filthy look, as though I'm scum of the earth sort of thing" (Ppt. 17, Para). Many openly berated themselves for their fears and responses:

Participant 10 (SP): And I thought that everybody else is normal and I'm not and I'm making it worse for myself 'cause I'm just having all these like, stupid thoughts.

Participant 2 (Para): Yeah, no stupid that I have the worries, I have the worries and they prove me to be stupid so it's not that I'm stupid mmm, mmm, getting a bit confused . . . umm, I don't, I'm stupid to have the thoughts 'cause I know they're there and I can't help them being there.

Although there were similarities between the groups in their self judgements, a number of those with paranoia reported extreme appraisals that may be associated with more fundamental beliefs about being bad:

Participant 11 (Para): I'm gonna let all the dirt and the filth out and what I was going – what I've been through an' 'cause you, uh well I do, I I I feel very dirty inside.

Participant 17 (Para): I mean, I, as you know I tend to think that people think I'm evil anyway.

Participant 17 (Para): . . . or I'm perverted or disgusting, filthy, all these things, smelly, revolting. . .

Parallel understanding or "minding the gap". It became clear that participants were able to hold their own beliefs about specific threats while simultaneously recognizing that others were likely to appraise their situation differently. Not only were people aware of this difference, it compounded their distress in two ways. First, this "parallel understanding" appeared to have a profound impact on how isolated people felt from those around them, and contributed to an awareness of their own difference from a desired normality.

Participant 3 (para): I just sort of, wh-when it happens I just think why does it always happen to me? Why can't I just do something like normal people do, you know why is it I just can't go book a holiday? Why is there always, always problems and, you know?

Participant 6 (SP): I know that in everyone else's life they don't act like me.

Participant 6 (SP): . . . so it just makes me feel lonely, like on my own, that there's no one – no one else understands.

Second, some people in the paranoia group struggled to judge the reality of their beliefs, given the discrepancy between these and others' likely appraisals, and so doubted their own thinking.

Participant 16 (Para): . . .wondering why I've got these ideas, and why I've got these ideas and are they real or not and to be quite honest with you, a lot of the time I can't tell whether it's real or not, and um, you know, I just sort of wonder where the ideas come from if they're not real or if they're not real then they're just sort of, I dunno, I can't, can't tell.

Participant 17 (Para): . . .but when I'm, when I'm ill, you don't, you just accept, accept what you hear and what you think as, as real. No matter if it's complete rubbish, you just think it's true. . .

Participant 4 (Para): Um, I, I try and tell myself that I'm just being paranoid, um, and that they're not really talking about me, um, but I still get the feeling that they are, even though I try to tell myself that they're not.

For both groups, the ability to recognize the difference between their beliefs and others' likely appraisals was linked to "judgements of self"; people were critical of their perceived inability to be normal, and both recognized and certainly "minded the gap"; participant 5 (SP) repeatedly asked the interviewer "does it sound daft?"

Coherence

A lack of narrative coherence was evident in many of the interviews in the paranoia group. This describes the extent to which participants were able to communicate a cogent and broadly consistent account of their experiences. At times, those in the paranoia group struggled to respond directly and with clarity to questions asked, and their responses became fragmented and confused. This superordinate theme emerged across all three of the major categories.

Researcher: Did you have any memories coming up into your mind on that occasion?

Participant 3 (Para): Uh well, I, I do, do that all the time I try to um, I try to, I sort of said when I saw K- I try to control my symptoms which is try not to look like I'm looking at people and things and of course it doesn't work it just makes it worse so. . .what was the question?

Participant 11 (Para): Well hopefully I've been taught different strategies to cope so, um, I think if, if I'd been taught how to cope, obviously being in and out of hospital, I think I'd be ab- I, that think that situation wouldn't have happened.

For some, when asked how they viewed their beliefs in hindsight, the interviewer understood the general gist of their responses, but struggled to understand these precisely:

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Participant 3 (Para): No fears I can, hundreds of times I can go back to, it's fear its um, just a real live fear.

Participant 16 (Para): Yeah, I mean, even if it was real it's distorted as well, you know, it can be distorted reality, I suppose that's what I mean.

Participant 9 (SP): Just tell yourself, not not doin anything wrong, and then you gotta think not all the time, that something can't be wrong all the time can ya?

This lack of coherence was not evident in the social phobia group, who were able to describe and reflect on their experiences of threat, and clarify any lack of understanding about questions with the interviewer.

Discussion and conclusions

Social phobia and paranoia are characterized by interpersonal threat beliefs, and the cognitive models indicate that similar psychological processes contribute to the maintenance of distress in both. Clinically, we can usually distinguish the two, but the similarities and differences in the experience and maintenance of threat in these groups are not yet fully understood.

This research examined the experience of threat in people with social phobia and others with persecutory delusions. This was in order to understand more fully the processes involved in the threat experience, in turn to inform clinical formulation and interventions aimed at reducing distress and disability.

Summary and discussion of findings

Three major themes emerged from the data: participants described their "experience of threat", their "reactions" at the time of threat, and their subsequent "reflections". These themes are unsurprising given the structure of the interview (see description above). Within each of these, subthemes emerged that indicate particular similarities and differences in psychological processes between the two groups.

Experience of threat

The experience of "threat and safety" was communicated forcefully by all participants. People with social phobia described a sense of imminent danger and corresponding desire for immediate safety. Those in the paranoia group also described a powerful sense of threat (cf Abba, Chadwick and Stevenson, 2008), yet focused more on the nature and feared consequences of the threat, often elaborating these in some detail for the interviewer. The tendency to develop elaborate constructions around their fears is not unusual in people with psychosis; clinically we know that people often describe complex (if not necessarily internally consistent) belief systems.

The second subtheme incorporated "affective, sensory and perceptual experience". Participants in both groups gave vivid descriptions of emotional and bodily sensations typically associated with severe anxiety. Differences emerged in participants' perceptual experiences, with some people in the paranoia group reporting hallucinations. In a non-clinical study of the differences between social anxiety and paranoia, perceptual anomalies

distinguished risk of paranoid reactions from risk of social anxiety, while measures of mood and cognition were similar (Freeman et al., 2008). The present findings are consistent with this, indicating that perceptual rather than affective responses differ between the groups, and that this is the case for clinical as well as non-clinical populations. In addition, the distinction between memories and hallucinatory experiences was at times unclear to people in the paranoia group; it may be that this is linked to their metacognitive skills, as discussed below.

The "attentional processing" subtheme was particularly interesting, and revealed a more complex picture than current cognitive models suggest. People in both groups reported strong feelings of self-consciousness in line with previous findings. When asked about their focus of attention, participants with social phobia and those with paranoia described attending both to others (as the source of perceived danger) and themselves (as the object of threat). This would indicate a more dynamic attentional focus than predicted by current theories, and may explain apparent discrepancies between models of social phobia that posit internal (e.g. Clark and Wells, 1995) and external (e.g. Rapee and Heimberg, 1997) focus of attention.

In addition, people in the two groups described both observer and field perspectives, with these perspectives changing over time. The Clark and Wells (1995) model suggests that people with social phobia adopt an observer perspective at times of interpersonal threat. Whilst this was supported by the present study, the results again indicate a more fluid process in which people may move between field and observer perspectives. Furthermore, it may be that the observer perspective itself is more complex than originally thought. Some people described seeing the threat situation from another person's view point and others from a wider "bird's eye view". If replicated, these findings suggest that cognitive models of social phobia and paranoia may need to be adapted to allow for this complexity in attentional focus and perspective taking, and that clinicians should assess these processes carefully in therapeutic work.

Reaction

Participants' reactions to the experience of threat were typical of fear responses and comparable across the two groups. Participants reported compelling, often racing streams of thought, and a clear sense of being trapped in these internal events. All participants attempted to manage the threat, and initiated coping behaviours ranging from attempts to control, escape or avoid the danger. These findings are consistent with the respective cognitive models that propose a range of cognitive and behavioural responses to manage interpersonal fears. Clark and Wells (1995) emphasize disconfirmatory processes in the maintenance of social phobia, while Freeman and colleagues (Freeman et al., 2002) posit both confirmatory and disconfirmatory processes in their model of paranoia. The participants interviewed for the present study emphasized reactions likely to maintain distress by preventing disconfirmation of beliefs (typically through behavioural or more subtle forms of avoidance) rather than confirmatory processes.

Reflection

The third subtheme "lost or decentred" clearly distinguished the two groups. Looking back on threat situations, most people with social phobia were able to "step back" or "decentre" from

the event, and review earlier appraisals of danger. By contrast, those with paranoia were unable to distance themselves in this way, and continued to report affect and cognition associated with an expectation of current danger.

Drawing on a combination of recent cognitive theory and Buddhist approaches to psychological distress, Teasdale and colleagues conceptualize the ability to decentre from internal experience as "metacognitive awareness", defined as "a cognitive set in which negative thoughts/feelings are experienced as mental events, rather than as the self" (Teasdale et al., 2002, p. 275). In a rigorous study of the role of this skill in people with residual depression, these authors found that poor metacognitive awareness was associated with vulnerability to relapse. Furthermore, metacognitive awareness increased in those participants with reduced relapse rates following psychological intervention (for both cognitive therapy and mindfulness based cognitive therapy). Teasdale and colleagues conclude that metacognitive awareness may be the key process of psychological change in the groups studied (Teasdale et al., 2002).

It is of note that participants in both the social anxiety and paranoia groups described a powerful sense of being overwhelmed and trapped at the time of interpersonal threat. Our results suggest that people with social phobia were able to decentre from these thoughts and feelings following the event, whereas those in the paranoia group showed poor metacognitive awareness, even looking back on the situation. This raises the interesting and important question of whether people with persecutory delusions have poor metacognitive awareness not only at times of distress, but subsequent to the immediate threat. The clinical implications are potentially considerable, and the hypothesis certainly requires further examination. Insofar as the ability to decentre from internal experience is likely to facilitate accurate identification of memories and current perceptual experiences, poor metacognitive awareness might also be linked to participants' inability to distinguish memories from hallucinatory experiences reliably.

In their "judgements of self" both groups reported problematic self appraisals, consistent with the cognitive models of social phobia and paranoia. There was some indication that participants in the paranoia group reported particularly extreme descriptions of the self (as evil and revolting, for example). Whether these beliefs were held at the level of automatic thoughts or at a more fundamental core belief level, was not assessed. Judgements of self certainly appear to be a key component in the threat experience of both groups, and are likely to require careful consideration in any psychological work.

The final subtheme in this section described participants' ability to hold their own threat beliefs alongside a recognition that others were likely to appraise the same situation differently. This "parallel understanding" is relevant in therapeutic work (particularly at formulation) when people are invited to consider alternative and historical explanations for current beliefs and distress. The fact that people with persecutory delusions also showed this parallel understanding is interesting when considered in combination with the hypothesis that these individuals may struggle to decentre from their internal experience, even in retrospect. In their work with people with psychosis, Garety and colleagues have discussed the "response to hypothetical contradiction" (e.g. Garety and Hemsley, 1994) as a useful tool in assessing how likely it is that someone would countenance an alternative explanation for their psychotic experiences. The current findings suggest that people with persecutory delusions are able to hold alternative explanations in mind, but may struggle to decentre from the threat beliefs.

Coherence

Finally, a lack of narrative coherence was evident in many of the interviews with participants in the paranoia group. In their important work on recovery and relapse prevention in psychosis, Gumley and Schwannauer (2006) note that the discourse of people with psychosis can become fragmented and impoverished, and suggest that this indicates traumatic or unresolved experiences. Following Greenburg and colleagues (Greenberg, Rice and Elliott, 1993) and Siegel (1999), these authors argue that the development of a coherent narrative linking the person's past, present and future, with their construction of self, and accommodating the compelling and pervasive emotional experiences of psychosis, is a key task in therapy. The present research is consistent with the suggestion that coherence of narrative is problematic for many people with persecutory delusions.

Limitations

Participants were not matched for age or gender. The findings are also limited by the lack of information on participants' mental state and medication use. The majority of people in the paranoia group were in receipt of outpatient care, and the majority of the social anxiety group were not receiving treatment at the time of the study. It may be that, overall, participants in the paranoia group were more unwell and taking more medication than those in the social anxiety group, and this may have affected the results, having an impact on coherence, for example.

Notwithstanding these limitations, theoretical and clinical implications may be drawn from this research. The study raises rather than answers questions. Interesting and potentially important hypotheses regarding attentional processes and metacognitive awareness can be formulated, and these will require further, possibly mixed methods analysis.

Theoretical and clinical implications

Recognizing the compelling and pervasive experience of interpersonal threat. All participants gave vivid and compelling descriptions of their experience of interpersonal threat. This study yielded a rich sense of these experiences, typical of qualitative studies. If we are to recognize and validate these experiences in our clinical work we need to emphasize the Rogerian skills of empathy, warmth and genuine regard, communicated through active and patient listening. These skills are perhaps easier said than done in the modern NHS in which economic constraints and contractual arrangements based on clinical contacts encourage short term work and early discharge. It is of note that certain authors focusing on the detail of therapeutic work with people with psychosis (Chadwick, 2006; Gumley and Schwannauer, 2006) suggest the use of formulation and ending letters as a way of validating and conveying the therapist's understanding of the person's lived experience (as well as perhaps aiding coherence of narrative or metacognitive awareness).

The role of formulation. Highly critical judgements of the self emerged as a key component in individuals' threat experiences. In addition to validating the person's sense of immediate and overwhelming threat (described above), it is likely that a recognition of the gravity of these appraisals needs to be communicated in therapeutic work. The model of social phobia

(Clark and Wells, 1995) places "processing of the self as a social object" at the centre of the formulation. This represents the person's "felt sense", and incorporates key judgements of the self, often in the form of an image. Given the present findings, it may be that a comparable representation would be valuable in models of paranoia, and indicate linked interventions.

Arguably, CBT and other formulation based approaches, rely on a person's ability to consider alternative explanations of current distress (in the form of the case conceptualization) and then be able to decentre from immediate internal experience. If the abilities to (i) hold "parallel understandings" of threat events, and (ii) develop a metacognitive or decentred awareness of internal experience, are necessary to therapeutic change, it would be valuable to name these processes in the formulation. The current findings suggest that people with persecutory delusions may be able to hold alternative explanations in mind, but struggle to decentre from their internal experience, even after the event. It is likely that these processes could be incorporated into "processing of the self" representations and provide the rationale to develop people's skills in decentred awareness where this is problematic, for people with persecutory delusions as well as in social anxiety.

Gumley and Schwannauer (2006) argue that a key task in therapy is the development of a coherent narrative. Traditional CBT certainly aims to make links between a person's past, present and future, incorporating the current experience of mental distress. The work of these authors emphasize the "process" of formulation, however, linking this explicitly to the construction of self, and the role of conceptualization in supporting narrative coherence. This is likely to take time. It may be that formulation is more usefully understood as a stage of therapy, with linked goals of developing coherent narrative and recognizing the psychological processes maintaining distress in situ, particularly for people with poor metacognitive awareness. Further research is now needed to work out how best to conceptualize these processes within the formulation, and then to examine the impact of interventions aimed at improving decentred awareness and narrative coherence.

Assessment of attentional processes. The "attentional processing" subtheme revealed a complex picture for both social phobia and paranoia participants. In addition to intense feelings of self-consciousness, participants described a fluid focus of attention, moving between themselves (as the object of threat) and others (as the source of perceived danger). Many also described fluidity in their adoption of observer and field perspectives. This has implications for the cognitive models of social phobia and paranoia, which may need to be adapted to allow for this complexity in attentional focus and perspective taking. Detailed examination of attentional processes over periods of distress, using measures that allow for change over short periods of time, is now required to elucidate these processes more fully.

Experimental research has long since highlighted the role of attentional processes in psychopathology (e.g. Bogels and Mansell, 2004); however, these studies often lack ecological validity and their findings may not to be incorporated into routine clinical work. As clinicians, we now need to assess attentional processes (specifically self-consciousness, focus of attention and perspective taking) and name these within psychological formulation if we are to work more effectively with our patients.

The role of metacognition. This study suggests that people with persecutory delusions may have poor metacognitive awareness, both at times of interpersonal threat and in retrospect. If Teasdale and colleagues are correct, that metacognitive awareness mediates therapeutic benefit in cognitive behavioural interventions (Teasdale et al., 2002), this process or skill

requires further investigation in this group. The lack of narrative coherence in the paranoia participants in this study, and the emphasis placed on addressing this in the clinical literature (Gumley and Schwannauer, 2006), may also reflect a tendency to poor metacognitive awareness in this group, and the need to address this if therapeutic work is to be effective.

It is probably fair to say that CBT interventions for people with paranoia are not yet as efficacious as those for other problems such as social phobia. If effective CBT involves the ability to decentre from distressing experience, and people with persecutory delusions struggle with this to a greater degree that people with problems traditionally termed "neuroses", it is likely that we need to pay far greater attention to this process in clinical work. As suggested above, the clinical implications might include assessing and naming the process in individuals' formulation, and assisting the development of this skill before engaging in change based interventions such as cognitive re-evaluation work or graded exposure to feared situations.

Summary

This study aimed to examine the psychological processes associated with interpersonal threat in people with social phobia and others with persecutory delusions. This is important because psychological interventions depend on clear and accurate formulation of distress, and so a detailed understanding of these processes is essential to effective therapeutic work.

The accounts of interpersonal threat experiences examined using qualitative thematic analysis yielded three major themes: participants' "experience of threat", "reactions" while under threat, and subsequent "reflections", as well as the superordinate theme of "narrative coherence". Typical fear responses were found in both groups, particularly in their reactions to threat, and key differences emerged between the groups in their perceptual experiences, ability to stand back from the threat following the event, and narrative coherence. These findings partially support the current cognitive models of social phobia and paranoia, and indicate areas for further development, particularly in terms of formulating attentional and metacognitive processes, in order to understand interpersonal threat experiences in these groups, and thus develop more effective means of alleviating associated distress.

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