The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 11, Issue 3, July- September, 2023
DIP: 18.01.165.20231103, DOI: 10.25215/1103.165
https://www.ijip.in

The International Journal of INDIAN PSYCHOLOGY

Comparative Study

The Role of Subclinical Paranoia in Social Cognition and Social Functioning among University Students- A Comparative Study

Diksha Patel[1]*, Rahul Varma[2]

ABSTRACT

A person with subclinical paranoia has mild or subtle paranoid beliefs, thoughts, or suspicions that are not severe enough to require a professional diagnosis. The current study aims to understand how social cognitions and social functioning of undergraduate university students between the ages of 18 and 23 are affected by subclinical paranoid. How closely these three variables are connected. The study also intends to investigate how ambiguous cues affect a person's level of paranoia. Three separate scales were applied to the study's 58 participants. The association and impact of ambiguous stimuli were determined using multiple linear regression techniques. According to the findings, social paranoia, social cognitions, and social functioning are all significantly positively correlated. Additionally, it discovered that after presenting the subjects with ambiguous stimuli, there is a slight but substantial change in the individuals' level of paranoia. Discussions were held in relation to this. In conclusion, the study highlights how young adults who experience more persecution have poorer social cognition and social functioning. As a result, interventions are needed, as well as ways for lowering the probability of fully functional paranoia and psychosis in the near future.

Keywords: *Subclinical Social Paranoia, Social Cognitions, Social Functioning, Persecution, Psychosis*

Paranoia can be defined as "A disordered pattern of thought that is determined by a severe, irrational but constant mistrust or suspicious behaviour towards people and a negative tendency to interpret the actions of others as very threatening or damaging". More recently, Freeman and Garety (2000) have defined paranoia as the belief that harm is occurring or will occur and that the persecutor intends to cause harm to the person. Paranoia occurs across a wide range of psychopathologies, such as depression, social phobia, personality disorder and psychosis (American Psychiatric Association, 1994).

In recent research, the emphasis has shifted from examining pathological illnesses as discrete diagnostic criteria to examining particular symptoms as they appear at different levels of severity, ranging from healthy to subclinical to clinical. However, it is also found that 10-15% of individuals in the general population experience paranoia at a higher extent.

[1]Scholar, Amity University Chhattisgarh
[2]HOI, Amity University Chhattisgarh
*Corresponding Author

Received: June 18, 2023; Revision Received: August 03, 2023; Accepted: August 08, 2023

© 2023, Patel, D. & Varma, R.; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (www.creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Paranoia is one of these symptoms and is commonly deeply investigated in serious mental disorders like psychosis. There has been a high correlation between high levels of social anxiety, depression, self-consciousness, low levels of self-concept, self-esteem and more subclinical paranoia. Comparing those with higher subclinical paranoid levels to those with lower levels indicates observable disadvantages, particularly in socially relevant domains like emotion perception and societal and social group functioning.

There is very little information about the various social cognitive processes found in paranoia and how these are related to social functioning in general. The present study will test the performance on social functioning and social cognitions and their relationship to social paranoia. A key or major element in this study will be the ambiguity in the perception of social expressions and the attributional blame, which appears to be a very significant yet neglected aspect in paranoia.

The aim of this introduction is to give an overview of the image of paranoia and research related at the current time and provide a rationale for the present study. The chapter of the introduction begins by considering how the term paranoia has been defined and elaborated with abnormality.

Defining Paranoia

Both in daily life and within psychiatric systems, the term "paranoia" is frequently used. Despite its widespread use, paranoia is still not fully understood as a phenomenon by society, and experts are continuously debating the numerous theories that explain it and the components that contribute to it. It is a complicated construct whose conceptualizations and definitions have changed over time.

There are two definitions of paranoia in the Oxford Dictionaries. According to the first definition, paranoia is "a mental disorder characterized by delusions of persecution, unjustified jealousy, or exaggerated self-importance, usually worked into an organized system," and according to the second definition, paranoia is an "unjustified suspicion and mistrust of other people." Maybe the two meanings show how the experience is seen differently, and the many meanings that the term refers.

The contrast between defining paranoia as a ‘mental condition’ versus ‘unjustified suspicious and mistrust’ hints at a lack of clarity as to whether paranoia exists on a continuum, or is an experience reserved for those thought to be mentally unwell. Compounding the ambiguity of the term, Freeman (2008) highlights that ‘paranoia’ has been used in different ways within research literature, often being used interchangeably with other terms such as persecutory delusions and persecutory beliefs or ideation within the literature, as well as to denote different concepts.

The Role of Social and Environmental Factors

The model puts forth that paranoid experiences (including associated thoughts and behaviours) arise through social learning. Reciprocal determinism is seen as key in an interactive process between the person and their environment, as well as emphasis is placed on multiple and idiosyncratic causalities. Causal factors are suggested to involve ‘specific nonspecific’ and ‘early learning-maintaining’ aspects.

'Nonspecific' determinants are those thought to result in both paranoid and other behaviours and are suggested to include experiences such as having difficult early interactions with caregivers, having an insular family, as well as experiencing inconsistency in the behaviour of others. 'Specific' determinants refer to aspects of the learning experience which are specific in producing paranoid behaviour such as the impact of the paranoid behaviour of others. The 'early learning-maintaining' causal experiences are said to include early modelling of paranoid ways of behaving, as well as reinforcement of the same, coupled with an inadequate amount of reinforcement of non-paranoid ways of behaving and relating.

Furthermore, learning from a history of confirmed suspicions is also thought to be a causal factor within this matrix. While it has not been subject to empirical investigation, this model highlights the importance of early learning environments in contributing to paranoid ways of behaving.

Paranoia, culture and Social norms
Freeman and Freeman (2008) speculate that paranoia is actually increasing in modern Western society, citing reasons such as migration, urbanisation, victimisation, trauma, and social isolation. They also draw attention to mistrust of authority and the effect of the media on people's perception of risk. Highlighting such factors represents a shift in focus from the paranoid individual to paranoia as a wider societal, cultural and even political issue. This normalising of paranoia leads to a conceptualisation of those who experience it as aware and alert individuals taking a critical stance toward knowledge (Knight, 2000) further loosening the association of paranoia as an experience reserved for the mentally ill.

The assertion that social, cultural, environmental and even political contexts can be key in the formation of paranoid thoughts and feelings in any individual lends further support to the continuum view of paranoia. Indeed, studies of the prevalence of paranoia in the nonclinical population do highlight that paranoia is a phenomenon of interest in its own right, and may, in turn, enable us to understand more about the nature of paranoia experienced by those using mental health services.

Paranoia's Frequency and Appearance in Subclinical Population
As mentioned above, recent research into the nonclinical population (particularly the last ten years) has supported continuum views over categorical views of health and illness. Initially research into the general population was broad in focus, with many studies investigating the presence of psychotic-like phenomena in the general population (e.g., Stefanis et al., 2002; Johns et al, 2004), amongst those without diagnoses or attachment to mental health services. In fact, a meta-analysis of prevalence rates of sub-clinical psychosis in the general population found a median prevalence of between 5-8% for such symptoms.

Interestingly, such psychotic-like experiences have been suggested as having higher rates in the adolescent population (Poulton et al., 2000; Laurens et al., 2007) as well as in the student population (Lincoln & Keller, 2008). More recently, the trend has been for research to investigate general population prevalence of 'single-symptoms' as mentioned above. So, attention will be turned to prevalence studies concerning the incidence of paranoia and persecutory delusions. However, our research is focused on identifying the level of paranoia when in group and giving ambiguous stimuli.

Social Cognitions and Social Functioning

A set of mental processes known as social cognition enable people to pay attention to and evaluate numerous facets of social interaction. persons with intact social cognition have reported higher levels of social satisfaction in their life.

Theory of Mind (ToM), social perception, attribution bias, and emotional processing are thought to be its four key domains. Instead of asking someone to self-report their capacity to competently make judgements in each of these areas, tests that demand evidence of that competency are frequently used to assess each of these (Couture et al., 2006).

An individual's interactions with their surroundings and capacity to carry out their responsibilities in settings like work, social interactions, and partnerships and family relationships are referred to as social functioning.

Also Meeting the essential needs of the individual and their dependents—including their bodily needs, personal fulfilment, emotional needs, and a healthy sense of self—is referred to as social functioning.

Social skills are crucial because they can improve your communication, which in turn can help you develop, maintain, and strengthen connections with co-workers, clients, and new contacts. Regardless of your job, industry, or level of expertise, retaining and improving these abilities is crucial.

Theory of Mind

The ability to understand others by attributing mental states to them (i.e., speculating on what is going on in their head) is referred to as theory of mind. This includes understanding that one's own mental states, which include beliefs, wants, intentions, emotions, and thoughts, may differ from those of others. It is believed that success in regular human social interactions depends on one's ability to have a functional theory of mind. People evaluate, judge, and extrapolate behaviour from others using this notion. Studies on animals and young children had a major role in the discovery and development of theory of mind. The ability to demonstrate theory of mind can be impacted by a variety of factors, such as drug and alcohol use, language development, cognitive impairments, age, and culture. Children's perceptions of individuals as mental entities with ideas, desires, emotions, and intentions, as well as actions and interactions that can be understood and explained by taking into account these mental states, are the subject of theory-of-mind research.

REVIEW OF LITERATURE

Paranoia is a major symptom of psychosis and has been linked to a variety of negative outcomes. Secure attachment style attenuates paranoia, but few researchers have examined the mechanism of change. Attachment theory has been presented as a major model in explaining this causal route, and earlier life experiences increase vulnerability to paranoid thinking. The association between an anxious attachment style and paranoia is the most potent and frequently noted one. Exploratory analyses on trait variables revealed that hyperactivating strategies mediated the association between attachment anxiety and paranoia, and suppression mediated the association between attachment avoidance and paranoia. Psychosis is a disorder characterized by abnormalities that are deviated from societal norms in one or more of the five domains **(David, 2010).** It has been linked to severe social deficiencies and interpersonal issues, with a focus on the connection between

social anxiety and paranoid ideas. Social exclusion or social isolation is a possibility for those who have psychosis.

Impaired social cognition and social functioning, which are connected traits seen in psychosis, may have an impact on social inclusion. Paranoia is characterised by a negative attributional style and varying degrees of paranoid ideation, and the main contributors to the amount of paranoia include theory of mind, attributional style, social/emotional perception, and group interaction. **(Dennis R Combus, Jacob A Finn**). The authors examined the effects of therapy aimed at lessening pathological confidence on patients' well-being and assessed the effectiveness of pharmaceutical and metacognitive interventions. It was stressed the importance of taking into account both primary and secondary cognition in the research of paranoid ideas. Cognitive models of psychosis implicate attributional biases as one of the mechanisms involved in the formation and maintenance of symptoms. Experiments 1 and 2 showed that interpretation bias could be explained by trait measures of paranoia/psychosis. CBM produced training-congruent changes in the interpretation of new ambiguous information and influenced the interpretation, attribution and distress associated with a real-life social event. Negative interpretation bias is a phenomenon caused by elevated vulnerability to affective disorders **(James Hurley, Sian Coker**).

The study examined the relationship between vulnerability to psychosis, measured by trait paranoia, and interpretation bias. Results revealed that trait paranoia, trait anxiety, and cognitive inflexibility predicted paranoid interpretation bias, while trait anxiety and cognitive inflexibility predicted negative interpretation bias. In a group comparison, those with high levels of trait paranoia were negatively biased in their interpretations of ambiguous information relative to those with low levels of paranoia. The Threat Anticipation Model implicates social anxiety, jumping to conclusions (JTC) and belief inflexibility in persecutory delusions. It was investigated whether Cognitive Bias Modification for Interpretation improves social anxiety by targeting negative interpretation bias of ambiguous social information.

The Maudsley Review Training Programme improved JTC/belief inflexibility and paranoia, as well as the Maudsley Review Training Program improved social anxiety in one case. Interpretation bias is a cognitive bias that generates and maintains persecutory beliefs/paranoid ideation. Studies have investigated the mediating role of anxiety and depression in the association between interpretation bias and paranoia in patients with persistent paranoia. The findings suggest that the association between interpretation bias and paranoid beliefs takes effect partly, although not completely, through heightened levels of anxiety.

Another study investigated the role of endogenous oxytocin in social approach and avoidance (AA) behaviour in schizophrenia. The results showed that patients with higher levels of oxytocin tended to avoid angry faces more, and greater avoidance of angry faces was correlated with more severe psychotic symptoms and greater paranoia. **(Cumhur Tas, Elliot C Brown) 2014**. Cognitive rehabilitation programmes for psychosis usually use metacognitive skill training, but this has little influence on social cognitive change. Finally, the Social Cognition and Interaction Training (SCIT) programme, a new group-based intervention designed to correct social cognitive biases in paranoid humans, could next be adapted and evaluated to test its efficacy as a therapeutic intervention.

Objectives and Hypotheses

The objectives of the Study

The present study has various objectives, these are-

- To explore the association between Social Paranoia, Social Cognition and Social Functioning.
- To determine the relationship between Subclinical Social Paranoia and Social Cognitions.
- To determine the effect of ambiguous stimuli on an Individual's paranoia level.

The hypotheses of the Study

- **Ho1**- There will be no significant association among social paranoia, social cognitions and social functioning.
- **Ho2-** There will be no significant relationship between Subclinical Social Paranoia and Social Cognition.
- **Ho3-** There will be no effect of ambiguous stimuli on an individual's paranoia level.

Variables

- Independent Variable- **State Social Paranoia**
- Dependent Variable- **Social cognition and Social Functioning**

METHODOLOGY

Exploratory research is a research method used to investigate a problem that is not clearly defined. It involves two ways of conducting it: primary and secondary, and the data gathered can be qualitative or quantitative. The study focuses on three aspects of psychology: social paranoia, social cognitions, and social functioning.

For the study, Participants must be Undergraduate University students, 18-23 years of age, Indian Nationality, and regular program University students. Exclusion criteria include accessing mental health support, having gone through therapies in the past, being married individuals, and being distant program University students. A total of 58 participants fills out the complete questionnaire and were recruited for the analysis.

The variables used are independent variables (social paranoia) and dependent variables (social cognitions and social functioning). The research is designed to understand the effect of ambiguous stimuli on paranoia and social cognition and to determine if the paranoia level increases or not after putting ambiguous stimuli.

Research Design

The design was designed into two phases. In the first phase the quantitative data was taken using three different psychometric scales. The design of the research was in such a way that made it clear that the participants from Phase I will only be the Participants for Phase II, so that the level of Social Paranoia, Social cognition and social functioning before and after can be known and inferences can be put. So, after the conduction of Phase I, all of the participants (n=58) were made to be the participants of phase II. However, the participants who didn't complete the questionnaire were not allowed for being participants for the second phase.

Instruments Used in the Study

- **State Social Paranoia Scale (SSPS):** State Social Paranoia Scale is developed by Fenig- stein and Vanable, 1992), the **20-item self-report Paranoia Scale** was developed to measure paranoia. In the overall sample, the internal reliability of the SSPS was excellent (Cronbach's alpha 0.91). Each item is rated on a 5-point scale (1-5) where the mark for the 'totally agree' is equals to 5 and the score for 'do not agree' is 1. Total scores range could be between 20 to 100, with higher scores indicating greater paranoid ideation.
- **Social Cognitions Questionnaire (SCQ):** SCQ is developed by Adrian Wells, Lucia Stopa & David M Clark, *this questionnaire assesses the frequency and degree of belief in 22 thoughts that may go through people's minds when they feel socially frightened or anxious. There is additional space for writing down and rating less common, more personalized "catastrophic" social concerns.* Reliability for the test was found good for all frequency and belief scales, ranging from 0.90 to 0.98.
  SCQ is divided into 2 other major components, 1st – frightened or nervous and 2nd – anxious. And for both components rating system is different. For 1st component, it is a 5-point rating scale. And for 2nd component, it is a scale of (0-100) where, zero means 'I do not believe' and hundred means 'I am completely convinced this thought is true'. More the score more the anxiety and nervousness are meant.
- **Social Functioning Questionnaire (SFQ):** Social Functioning Questionnaire is developed by Tyrer, P, Nur, U, Crawford, M, Karlson, S, MacLean, C, Rao, B, Johnson, T (2005). The Social Functioning Questionnaire: a rapid and robust measure of perceived functioning. This 8-statement tool for quick assessment of social functioning. Validated in study of over 4000 subjects. Scoring of SCQ is very simple. If the score is more than 8 than it says to have poor social functioning.

Data Collection

Phase I of the data collection entails gathering quantitative data with demographic information, such as name, age, gender, educational year, area (rural/urban), and ethnicity. The Social Paranoia Scale, a social cognition questionnaire, and a social functioning scaler were used to collect the quantitative data. It was emphasised that participants should provide their respective contact information because they would later be asked to join phase II of the study.

Phase II is the core of the study. Here, Social cognitions and social functioning are used as dependent factors in the study's comparative design, whereas social paranoia is used as an independent variable. Furthermore, ambiguous stimuli and gender are unrelated factors that affect social anxiety and social cognition.

The second phase of the data collection and procedure was interesting. So, after the data collection of Phase I, the Gap of around 7-14 days was given to all the participants to avoid the test-retest memory effect. On the 14th day of the gap, the participants were instructed that their presence will be needed so they have to be present on the following day. In Phase II, the following changes took place-

- For easy conduction, two groups were formed randomly.
- The participants of these group were shuffled, and the participant was made to sit in such a place where they don't know who is sitting next to them.

- The room was dark.
- They didn't know why they were being called in a room.

There are 29 participants per group. The first group was called, and each participant was instructed to take a seat comfortably. Then, two paranoia-related videos were played for the group. The first video lasted one minute, while the second one lasted two minutes and 34 seconds. Group A was given both videos and after that, it was told to answer the identical question on the questionnaire as they had in Phase I.

Group A was instructed to leave after finishing their questionnaire and receiving encouragement. Participants from Group B were then called, taken to their seats, and given identical instructions before seeing a one-minute slide-show presentation and getting two videos. Identical questionnaires were given to them as well. After finishing, members of group B were thanked and told to leave the room.

RESULT AND ANALYSIS

The purpose of the data analysis is to arrange, categorise, and summarise the information gathered so that it may be understood and interpreted to respond to the inquiries that drove the research project.

In the study, the statistical techniques used are as follows-

- Descriptive Analysis- the Mean, Standard Deviation and Percentage
- Regression Analysis- Liner Regression Model, Pearson correlation.

Table no -01 Descriptive Analysis of Social Paranoia, social cognition and social functioning of the Participants from Phase I and Phase II

		Phase I			**Phase II**		
S.NO.	**Particulars**	**SSP**	**SC**	**SF**	**SSP**	**SC**	**SF**
1.	Total no. of observations	58	58	58	58	58	58
2.	Mean	49.43	785	7.43	49.90	802.16	8.02
3.	Standard deviation	10.079	534.576	2.968	10.647	436.191	2.336
4.	Percentile (P_{25})	42	386.25	5	42.75	460.00	6.00
5.	Percentile (P_{50})	48	697.50	7	49.00	705.00	8.00
6.	Percentile (P_{75})	55	1128.75	9.25	58.00	1100.00	9.00

The most important details are the descriptive analysis with respect to social paranoia, and social cognitions. The mean of central tendency was 19.17, which indicates that the age is relatively close to the mean, with more age years falling within the range of 18 to 21 years. The percentile was 18, 19, and 20 respectively, which indicates that for P25, 25% of the observations are below the data value 18, and for P50, 50% of the observations are below the data value 18, and for P75, 75% of the observations are below the data value 55. The mean of central tendency is 7.43 and the standard deviation of the variable paranoia is 2.968. The percentile used in statistics is 386.25, 697.50 and 1128.75, which indicates that 25% of the observations are below the data value 386.25, 50 of the observations are below the data value of 697.50 and 75% of the observations are below the data value of 1128.75.

the descriptive analysis of the subjects with respect to their paranoia, social functioning and social paranoia of phase 2 is described. The mean of the central tendency of paranoia, social cognition and social functioning is 49.20, 802.16 and 8.02 respectively. The standard deviation of all three variables is 10.647, 436.191 and 2.336. The percentile used in statistics is a measure which indicates the value below which a given percentage of observation under a group of observation fall. The percentile used in statistics is 6,8 and 9 respectively.

Regression Analysis

Table no- 02- Linear Regression model showing R-value of Phase I and Phase II

	Phase I				**Phase II**			
Model	**R**	**R^2**	**Adjusted R^2**	**Std. error of the Estimate**	**R**	**R^2**	**Adjusted R^2**	**Std. error of the Estimate**
(SSP &SC)	0.396	0.157	0.141	495.325	0.382	0.146	0.131	406.693
(SSP & SF)	0.222	0.049	0.032	2.920	0.330	0.109	0.093	2.224
(SC & SF)	0.466	0.216	0.203	2.650	0.460	0.212	0.198	2.092

Table no- 03 Regression model of three variables of Phase I

Model	**Sum of squares**	**df**	**Mean Square**	**F**	**Sig.**
Regression (SSP and SC)	2549568.420	1	2549568.420	10.392	0.002*
Regression (SSP and SF)	24.706	1	24.706	2.897	0.94
Regression (SC and SF)	108.864	1	108.964	15.498	0.000*

** Correlation is significant at the 0.05 level*

Table no- 04 Regression model of three variables of Phase II

Model	**Sum of squares**	**df**	**Mean Square**	**F**	**Sig.**
Regression (SSP and SC)	1582610.568	1	1582610.568	9.568	0.003*
Regression (SSP and SF)	33.912	1	33.912	6.854	0.11
Regression (SC and SF)	65.798	1	65.798	15.028	0.000*

** Correlation is significant at the 0.05 level*

Table no- 05 Correlation of all three variables of phase I

Correlation	**State social paranoia**	**Social cognition**	**Social functioning**
State social paranoia	1	0.382**	0.330*
Social cognition	0.382**	1	0.460 **
Social Functioning	0.330*	0.460**	1

**Correlation is significant at the 0.05 level (2-tailed).*

*** Correlation is significant at the 0.01 level (2-tailed)*

Linear regression method of analysis was used to identify the association between three variables, i.e., Social Paranoia, Social Cognition and Social Paranoia. Table no-02 was created using the results of all three regressions, with R square values of 0.157, 0.049, and 0.216, respectively, indicating their respective variance ranges of 15.7%, 4.9%, and 21.6%.

Table no-03 showed the relevance of the data for each variable, with State Social Paranoia and Social Cognition having a 0.002* significance level, State Social Paranoia and Social Functioning having a 0.94* significance level, and Social Functioning and Social Cognitions having a 0.000* significance level. Phase-I concluded that State Social Paranoia and Social Cognition are correlated and significant, while Social Functioning and Social Cognition are moderately correlated and highly significant. The linear regression model was used to determine the relationship between all three variables and the significance of these variables.

Table No. 03 was created using the results of all three regressions, with R square values of 0.146, 0.109 and 0.212 respectively, indicating that their respective variance ranges are 14.6%, 10.9%, and 21.2%. Table No. 04 showed the relevance of the data for each variable, with State Social Paranoia and Social Cognition having a 0.003* significance level, and Social Functioning and Social Cognitions having a 0.000* significance level. The null hypothesis was rejected because there is evidence of a link between all three of these variables. The mean of social paranoia from phases I and II is 49.43 and 49.90, respectively, and the null hypothesis is rejected because ambiguous stimuli do have an impact on the paranoid level.

INTERPRETATION AND DISCUSSION

This study focused on the association between Social State Paranoia, Social Cognition and Social Functioning and the effect of stimuli on the level of paranoia of the participants. The null hypothesis was rejected because the goal was to discover the correlation between these variables. The third null hypothesis was confirmed, and it was determined that there is no relationship between social paranoia and social functioning. Other factors such as social group membership, personality qualities, and attachment preferences may also influence a person's social cognition and social functioning. A higher sample size may be used to provide a more comprehensive grasp of this.

The study found that those with high nonclinical paranoia levels may have more difficulty identifying subtle emotional displays than salient ones. Follow-up studies showed that mild negative emotions were more harmful than positive ones. Childhood experiences also play a major role in having paranoid ideations. Paranoid personality was not measured, but the subclinical social paranoia scale was used. Freeman and Garety found that individuals' lives had been adversely impacted by paranoia, with participants reporting that their relationships had been impacted and they believed that neutral events would cause them more harm in the future.

The most important details in this text are that many participants felt paranoid about bodily injury and being the victim of a conspiracy when it came to the threat's nature, but social evaluative concerns, ideas of reference, and worries about a mild threat were more prevalent. An earlier study found that paranoid people have more difficulty processing confusing inputs, which may potentially make them more paranoid. People with high degrees of nonclinical paranoia displayed higher felt animosity and guilt towards others for unpleasant ambiguous social situations. This finding may be explained by the fact that people with paranoia frequently exhibit a strong need for closure, which prevents them from considering other explanations for another person's actions.

Paranoia causes people to place a lot of emphasis on blaming others for ambiguous negative events. In terms of social functioning, those with high levels of nonclinical paranoid

reported fewer social contacts and a diminished tendency to engage others in social discourse. Additionally, they were less likely to mention being in public locations or going to events with other people. Haynes (1986) found that paranoid people tend to have poor social skills, which can cause them to interact negatively with social cognition. The sample size is entirely made up of college students, which is one of the study's weaknesses, but in related research, it was discovered that even college students with high levels of paranoia (undiagnosed) displayed greater social distance and greater hostility.

The present study is an attempt to assess the social paranoia, social functioning and social cognitions of undergraduate university students. This study opens new areas for further exploration in this field and identifies certain points of which practising professionals and might every individual should take note. The study expands the field of knowledge on root causes, underlying mechanisms, and efficient treatments. This also includes looking into the cognitive processes involved in the formation and upkeep of paranoid thoughts. A longitudinal study on the emergence of paranoia will shed more light on social influences and provide ways to avoid paranoid thoughts. In addition, the trustworthy element might be included to help evaluate persecutory beliefs. Personality qualities can also be evaluated in order to gain a better knowledge of social cognitions, paranoia, and social functioning. This will make it easier to comprehend the danger factor.

CONCLUSION

The present study investigated paranoia in a subclinical population of young adults. The findings highlight both social and personal factors that are related to paranoia. the study explored the ways that how cognition affects by paranoia, and how well their functioning is. The finding suggests that social cognition and social functioning of the self are related to paranoid thoughts, and beliefs while leading to subclinical paranoia. This study was among young adults which helps to know about social perception and social functioning when they are in a social group. The participants were made to watch videos (ambiguous stimuli) and as a result, their level of paranoia tend to rise. The finding is supported by the data on the 58 samples which suggests that paranoia is a common experience in a subclinical sample of undergraduates.

REFERENCES

Allardyce, J., Suppes, T., & van Os, J. (2007). Dimensions and the psychosis phenotype. International Journal of Methods in Psychiatric Research, 16(1), 34-40.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: American Psychiatric Association.

Asensio-Aguerri, L., Beato-Fernández, L., Stavraki, M., Rodríguez-Cano, T., Bajo, M., & Díaz, D. (2019, August 29). Paranoid Thinking and Wellbeing. The Role of Doubt in Pharmacological and Metacognitive Therapies. Frontiers. https://doi.org/10.3389/fpsyg.2019.02099

Aubrey M. Moe, Heather M. Wastler, Jacob G. Pine & Nicholas J. K. Breitborde (2023) Metacognitive Skills Training and Computerised cognitive remediation among individuals with First Episode of psychosis: influence social cognition, Psychosis, Doi: 10.1080/17522439.2022.2111595

Bandura, A. (1977) Social learning theory. Englewood Cliffs, N.J.: Prentice-Hall

Bebbington, P. E., McBride, O., Steel, C., Kuipers, E., Radovanovič, M., Brugha, T., ... & Freeman, D. (2013). The structure of paranoia in the general population. The British Journal of Psychiatry, 202(6), 419-427.

Bentall, R. P., Kaney, S., & Bowen-Jones, K. (1995). Persecutory delusions and recall of threat-related, depression-related, and neutral words. Cognitive Therapy and Research, 19(4), 445-457.

Bentall, R. P., Kinderman, P., & Kaney, S. (1994). The self, attributional processes and abnormal beliefs: towards a model of persecutory delusions. Behaviour Research and Therapy, 32(3), 331-341.

Berry, K., Barrowclough, C., & Wearden, A. (2008). Attachment theory: a framework for understanding symptoms and interpersonal relationships in psychosis. Behaviour Research and Therapy, 46(12), 1275-1282

Boyd, T., & Gumley, A. (2007). An experiential perspective on persecutory paranoia: A grounded theory construction. Psychology and Psychotherapy: Theory, Research and Practice, 80(1), 1-22.

Cella, M., Sisti, D., Rocchi, M. B., & Preti, A. (2011). Delusional profiles among young adults: a latent class analysis of delusion proneness. Psychiatry Research, 185(1), 97-101.

Colbert, S. M., & Peters, E. R. (2002). Need for closure and jumping-to-conclusions in delusion-prone individuals. The Journal of Nervous and Mental Disease, 190(1), 27-31.

Combs, Dennis R., and David L. Penn, 'Social cognition in paranoia', in Daniel Freeman, Richard Bentall, and Philippa Garety (eds), *Persecutory Delusions: Assessment, Theory, and Treatment* (Oxford, 2008; online edn, Oxford Academic,1 Sept. 2015), https://doi.org/10.1093/med:psych/9780199206315.003.0009,

Cromby, J. & Harper, D. J. (2009). Paranoia A Social Account. Theory & Psychology, 19(3), 335-361.

Freeman, D. (2006). Delusions in the nonclinical population. Current Psychiatry Reports, 8(3), 191-204

Garety, P. A., & Freeman, D. (1999). Cognitive approaches to delusions: a critical review of theories and evidence. British Journal of Clinical Psychology, 38(2), 113-15 https://doi.org/10.1111/bjc.12231

Independently of psychotic symptoms in FEP, employment and depression may have some impact on social inclusion. Sue M.Cotton, Kelly Allott, Kate M. Filia, Robert Hester, Eóin Killackey, 2017

Katherine Berry, Christine Barrowclough, Alison Wearden, A review of the role of adult attachment style in psychosis: Unexplored issues and questions for further research, Clinical Psychology Review, Volume 27, Issue 4, 2007, Pages 458-475, ISSN 0272-7358,

Martin, J. A., & Penn, D. L. (2001). Social cognition and subclinical paranoid ideation. British Journal of Clinical Psychology, 40(3), 261-265

Melo, S. S., & Bentall, R. P. (2010). Coping in subclinical paranoia: A two nations study. Psychology and Psychotherapy: Theory, Research and Practice, 83(4), 407-420.

Mirowsky, J., & Ross, C. E. (1983). Paranoia and the Structure of Powerlessness. American Sociological Review, 48(2), 228–239. https://doi.org/10.2307/2095107

Paula Castilho, Maria João Martins, Ana Margarida Pinto, Ricardo Viegas, Sérgio Carvalho, Nuno Madeira, Understanding the effect of attachment styles in paranoid ideation: The mediator role of experiential avoidance, Journal of Contextual Behavioral Science, Volume 6, Issue 1,2017,

Peters, E., Linney, Y., Johns, L. & Kuipers, E. (2007). Psychosis: Investigation. In S. Lindsay & G. Powell (Eds.), The handbook of clinical adult psychology (pp.354-373). London: Routledge

rüne, M. (2005). "Theory of mind" in schizophrenia: a review of the literature. Schizophrenia Bulletin, 31(1), 21-42

Savulich G, Edwards A, Assadi S, Guven H, Leathers-Smith E, Shergill S, Yiend J. Biased interpretation in paranoia and its modification. J Behav Ther Exp Psychiatry. 2020 Dec; 69:101575. doi: 10.1016/j.jbtep.2020.101575. Epub 2020 May 4. PMID: 32505999.)

This conceptualisation of paranoid thinking has found empirical support (e.g., Bentall, Corcoran, Howard, Blackwood, & Kinderman, 2001; Ellett, Lopes, & Chadwick, 2003; Freeman, 2006; Freeman, 2007; Freeman & Garety, 2014.

Acknowledgement

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Patel, D. & Varma, R. (2023). The Role of Subclinical Paranoia in Social Cognition and Social Functioning among University Students- A Comparative Study. *International Journal of Indian Psychology*, *11(3),* 1705-1717. DIP:18.01.165.20231103, DOI:10.25215/1103.165