

Paranoid Personality Disorder

Description/Etiology

Paranoid personality disorder (PPD) is one of 10 diagnosable personality disorders that appear in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*), all of which are retained from the fourth edition of the manual. PPD is grouped with schizoid personality disorder and schizotypal personality disorder to form the cluster A personality disorders, which share the appearance of eccentricity and oddness. The *DSM-5* general criteria for all 10 personality disorders include significant variation in behavior and internal life experience from one's own cultural norms in at least two of four areas, cognition, affectivity, interpersonal functioning, and impulse control. Also, a long-term and consistent history across a variety of life situations apparent since at least adolescence that has caused significant disturbances in functioning in important areas of life and which could be described as an abiding pattern, one that is not caused by another mental health disorder, including substance use disorder(s), impact of medications, or a medical condition.

The specific criterion for PPD is a deep and persistent distrust of others, including assuming that the intent to cause harm is present. To be diagnosed, at least four of seven specific criteria must be met. These are unfounded suspicions that others are out to exploit, harm, or deceive the individual; preoccupation with doubts related to the loyalty and trustworthiness of others; a reluctance to confide in others out of a fear of being used; interpretation of hidden threatening messages in benign comments or events; holding grudges that are persistent; perception of attacks on character that are not apparent to anyone else, with quick counterattack; and recurrent suspicions related to the fidelity of one's partner without justification. Also, these criteria do not occur in association with a diagnosis of schizophrenia, bipolar or depressive disorders, or another psychotic disorder and are not caused by a medical condition. The absence of delusions and hallucinations distinguishes PPD from psychotic disorders, although short-lived delusions and hallucinations may occur. Delusions can be distinguished from paranoid thoughts by their complete lack of plausibility (e.g., believing the CIA has implanted a broadcasting device in one's head versus believing that a coworker is listening to one's private phone calls). Individuals with PPD may appear quick to make negative judgments, hostile, emotionally volatile or unemotional, cold in personal relationships, controlling, brittle, blaming, extremely independent, rigid in their thinking, uncompromising, quiet, aloof, quick to anger or rage, overly concerned about status and rank, and above all suspicious and extremely vigilant for perceived threats. Cultural considerations related to PPD include language/communication barriers and unfamiliarity with cultural norms that may be perceived as hostility. Persistent substance abuse may cause signs and symptoms similar to PPD and should be ruled out as a source of symptoms. There may be overlap with symptoms and diagnosis of other cluster A disorders.

Personality is generally agreed to refer to the internal organization and evolution of an individual's psychobiological and social inheritance and learning that enable him or her to live in and adapt to a constantly changing world. One model of personality is the five-factor model (FFM), which divides and measures personality using five traits: openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism. Each trait is measured using a continuum (e.g., for agreeableness, friendly/compassionate to cold/unkind). PPD can be viewed as a demonstration of the extreme cold/unkind end of the agreeableness trait, overwhelming all the other traits. To be considered disordered, the sum of these five traits must be dysfunctional on both an individual and a social level,

ICD-9
301.0

ICD-10
F60.0

Author

Chris Bates, MA, MSW

Cinahl Information Systems, Glendale, CA

Reviewers

Laura Gale, LCSW

Cinahl Information Systems, Glendale, CA

Jessica Therivel, LMSW-IPR

Cinahl Information Systems, Glendale, CA

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and typically these traits are inflexible and outside the norms of the individual's culture. Furthermore, individuals with PPD usually lack awareness that there are problems in their personal or social functioning.

Controversy surrounds the personality disorders and is reflected by the inclusion in the *DSM-5* of a chapter titled "Alternative *DSM-5* Model for Personality Disorders" in Section 3, "Emerging Measures and Models." The alternative model was introduced to address shortcomings in the current model, including that many individuals simultaneously meet the criteria for several personality disorders and that the general categories of "other specified" or "unspecified" are the most often diagnosed yet are uninformative about the individual. A larger question about the personality disorder diagnosis, is its categorical nature (meaning either the criteria are met and there is a disorder/diagnosis, or the criteria are not met and there is no disorder/diagnosis) as opposed to the dimensional nature (meaning that personality traits occur along a continuum from not present at all to having overwhelming impact) of actual human behavior and lives. The *DSM-5* personality disorders remain categorical, yet the alternative model introduces the concept of dimensional assessment. Another issue of contention is the theory that personality disorders are actually a point on the continuum of a larger mental health disorder, usually at the less impactful end of a dimensional model. In the case of PPD, the debate centers on whether PPD and other disorders with a primary feature of delusion are on a continuum with schizophrenia or form a separate spectrum of paranoid disorders.

The etiology of PPD is unresolved, with most literature attributing it to an interaction of genetically inherited traits and environmental influences, particularly maltreatment in childhood. Additionally, individuals with PPD rarely seek treatment unless there is another mental health disorder present or they are mandated to treatment by courts, both of which complicate assessment, treatment, and research into PPD. The viability of treatment for personality disorders is the subject of debate, with some literature claiming that individuals with personality disorders are unreceptive to treatment and some asserting that the problem with treatment lies with professionals who blame their countertransference and lack of success on the individuals with personality disorders. Individuals with PPD are much more likely to respond positively to treatment using individual rather than group modalities. Investigators have reported success in treating PPD using cognitive analytic therapy (CAT), a brief, structured intervention that incorporates cognitive strategies and transparency about the therapeutic process (Kellett & Hardy, 2014).

Facts and Figures

The nature of PPD makes it difficult to recruit individuals for studies, so facts and figures are difficult to verify. The *DSM-5* reports the prevalence of between 2.3% and 4.4% and notes that PPD is diagnosed more often in men (p. 651). A review of admissions to a Danish psychiatric hospital between 1975 and 2000 for diagnosis of PPD on the first admission found more males than females, the equal division between urban and rural dwellers, and a distribution of education levels similar to that of the general population (Birkeland, 2011). Multiple studies have indicated racial differences in the diagnosis of PPD, with PPD diagnosed more often in Blacks than in Whites. In some studies, the racial difference has been attributed in part to lower socioeconomic status (Iacovino et al., 2014). It is theorized that the victimization and cultural mistrust that is experienced by many Black Americans is assessed as meeting the paranoia criteria for PPD. Perceived discrimination can often be correlated with paranoid delusions (Raza et al., 2014). Furthermore, an increased belief in the supernatural among Blacks may be behind the elevated levels of paranoia found in studies that compare rates of PPD among Blacks and Whites (Raza et al., 2014). In one study that examined participants in a substance treatment program, researchers found that 24% of the Black participants met the criteria for PPD, compared to 10% of the White participants (Raza et al., 2014).

Risk Factors

As with other aspects of PPD, identifying risk factors is complicated by the debate regarding the nature of the disorder and the difficulty of recruiting individuals for research. However, there is a generally agreed-upon higher risk for individuals with first-degree relatives in whom schizophrenia or other cluster A personality disorders have been diagnosed. Various environmental factors have been researched without conclusive findings, but some studies have found maltreatment or neglect during childhood to be possible markers for developing PPD. An additional childhood or adolescent trait that is considered a hallmark for development of PPD is an inability to experience pleasure (i.e., anhedonia). Traumatic brain injuries also can increase the risk for PPD. Substance use disorder has been correlated with the development of PPD. In a study researchers identified three patterns in the childhoods of individuals with paranoia: early experiences in childhood consisted of problematic relationships and victimization; the results of those early experiences were inconsistent view of self, negative beliefs about other persons, and substance use; and use of avoidance to cope with adversity (Dickson et al., 2016). Researchers in another study found that a predictor of paranoia in adulthood was having childhood memories marked by antipathy from a parent as well as bullying and victimization (Carvahlo et al., 2016).

Signs and Symptoms/Clinical Presentation

Signs and symptoms include broadly held distrust and suspiciousness, a formal and businesslike manner, poor eye contact, projection of blame for difficulties in life, extreme concern about the emotions and attitudes of others, difficulty in interpersonal relationships, social isolation, hypersensitivity, jealousy, rigidity, hypervigilance, antagonism, and aggression. Some signs and symptoms may appear contradictory.

Social Work Assessment

› Client History

- Standard biopsychosocial-spiritual history, including risk for suicide
- Observations of functioning and demeanor during the interview
- Collateral information from family, friends, and coworkers is especially important because individuals frequently have limited insight into the inappropriateness of their beliefs and behavior

› Relevant Diagnostic Assessments and Screening Tools

- Care should be used with self-reporting screening tools due to the client's general lack of insight. The tools listed are not specific to PPD, but are used for general measurement of personality dysfunction; some may have to be administered by a trained professional
 - Structured Clinical Interview for DSM-5 (Personality Disorders) (SCID-5-PD)
 - Personality Diagnostic Questionnaire–Revised (PDQ-R)
 - Minnesota Multiphasic Personality Inventory (MMPI)
 - Millon Clinical Multiaxial Inventory (MCMI)
 - Temperament and Character Inventory (TCI)

› Laboratory and Diagnostic Tests of Interest to the Social Worker

- At present, there are no laboratory or medical diagnostic tests available
- Tests for the presence of alcohol or other substances at levels indicating abuse may be useful
- The social worker may want to investigate whether there are any scans or past medical history that indicate a previous head trauma

Social Work Treatment Summary

Individuals with PPD rarely seek treatment, and if they do it is likely that another mental health disorder, most often depression or anxiety, has prompted them to consider the services. Usually, it is difficult to engage individuals with PPD in therapy because of the nature of the disorder: extreme distrust, suspicion of the motives of others, and belief that others are intent on causing harm. Lack of insight and concern about dysfunction further complicates engagement and progress in treatment, which may cause clinicians to lose interest in treatment. A commonly repeated myth holds that individuals with personality disorders are untreatable or that personality disorders are inflexible and cannot be treated. Research shows, however, that progress can be made if barriers to treatment are not erected. The three most common barriers are strong and counterproductive feelings of countertransference; the clinician's belief (and covert communication of this belief to the individual being treated) in the myth of untreatability; and the clinician's giving direct and specific advice on social functioning or personal problems, which usually produces dependence, noncompliance, or resentment. Establishing a therapeutic alliance with individuals with PPD is particularly difficult because of the profound distrust that is at the heart of PPD. Antianxiety or antipsychotic drugs may help manage anxiety and agitation. Some research suggests that medications may be helpful in decreasing paranoid ideation, yet distrust may forestall medication adherence. The first step in the treatment of PPD is a collaborative goal setting about treatment. Clinicians should immediately give attention to developing and maintaining a therapeutic alliance. Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

Problem	Goal	Intervention
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Client with PPD is exhibiting signs of aggression and threatening behavior, causing severe disruption of social or occupational relationships; or has symptoms of depression or anxiety	Reduction in disruptive behavior and depression and anxiety symptoms	Schedule appointment with a mental health professional who can prescribe appropriate medications. Follow up with family and caregiver on medication adherence and effectiveness, including discussion of the importance of adhering to prescription dosage and timing with family and caregivers while remaining sensitive to developing trust. Establish stability to allow for participation in other forms of treatment
Client is having difficulty in establishing a therapeutic alliance with a social worker	Establish a therapeutic alliance to allow for engagement in treatment interventions	Use of patience, validation, and unconditional positive regard by the therapist. Care must be used not to let an overly warm or familiar manner be perceived as threatening: A more businesslike manner may be more effective in the beginning, and giving more control to the client may help him or her preserve a sense of autonomy
Client is experiencing disrupted or inappropriate social or occupational interpersonal relationships	Establish or reestablish productive and functional social or occupational interpersonal relationships	Using individual rather than group methods, employ cognitive behavioral methods, psychodynamic therapy, and skills training as appropriate to the client

Applicable Laws and Regulations

- › Each jurisdiction (e.g., nation, state, province) has its own standards, procedures, and laws for involuntary restraint and detention of persons who may be a danger to themselves or others. Individuals with PPD may be at risk for involvement with the criminal justice system due to aggressive behavior or their own initiation of legal action. Local and professional reporting requirements for neglect and abuse should also be known and observed
- › Internationally, social workers should practice with awareness of and adherence to the social work principles of respect for human rights and human dignity, social justice, and professional conduct as described in the International Federation of Social Workers (IFSW) Statement of Ethical Principles, as well as the national code of ethics that applies in the country in which they practice. For example, in the United States, social workers should adhere to the National Association of Social Workers (NASW) Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards that apply to clients with paranoid personality disorder and practice accordingly (NASW, 2008)

Applicable Services and Resources

Enter “paranoid” or “personality disorder” in the search box to access relevant information available on each website.

- › National Alliance on Mental Illness (NAMI), <http://www.nami.org/>
- › U.S. National Institutes of Health (NIH), <http://www.nih.gov/>
- › U.S. National Institute of Mental Health (NIMH), <http://www.nimh.nih.gov/index.shtml>
- › National Association of Social Workers (NASW), <http://www.socialworkers.org/>

Food for Thought

The *DSM-5* states that the traits exhibited by individuals with PPD may be adaptive, meaning they may be beneficial to the individual in enabling functioning. In particular, the traits of PPD may be adaptive in threatening or hostile environments. Attention should be paid to the client's level of distress and/or the disruption in his or her social or occupational functioning before considering a diagnosis of PPD.

Red Flags

- › Individuals with PPD may engender strong positive or negative feelings in clinicians that may lead to countertransference
- › PPD may be difficult to diagnose because it is hard to distinguish from other cluster A personality disorders, from prodromal schizophrenia, and from delusional disorders
- › The myth that personality disorders are untreatable can be self-reinforcing when repeated among professionals involved in the treatment of PPD

Discharge Planning

- › Review medication regimen and make a follow-up appointment with agency issuing a prescription
- › Assess the stability of employment and living situation
- › Refer to appropriate treatment modality
- › Assist the client in locating support resources
- › Provide referrals for support and education for family members

DSM-5 Codes

- › Paranoid Personality Disorder 301.0

Note

- › Recent review of the literature has found no updated research evidence on this topic since the previous publication on June 2, 2017.

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