The focus of this module is paranoid personality disorder (PPD), a condition in which mistrust of others is the cardinal feature. PPD is a somewhat neglected topic, and is often the subject of diagnostic confusion and therapeutic pessimism. The research base on the disorder remains sparse, however an understanding of underlying psychological processes can assist with its assessment and treatment.

Although a certain degree of mistrust with respect to the intentions of others is normal, particularly in certain social situations, suspiciousness may become maladaptive. Clinically significant paranoid features are found in a variety of contexts: in previously healthy individuals subjected to abnormal stress; in mental illness; and in those with personality disorders.

This module presented a summary of the key diagnostic issues relating to PPD and described the various psychological and social processes mooted to be central to the genesis of paranoid thinking and behaviours. The evidence relating to PPD and violence risk was summarised and clinically useful guidance for the safe treatment of sufferers was outlined.

Diagnostic issues

- PPD is common in psychiatric populations.
- DSM-V describes features of PPD; Bernstein & Usada propose alternative ‘primary traits’.
- Clarifying the diagnosis of a patient with paranoid thinking is an essential first step to management, with implications for prognosis, treatment and medico-legal issues such as involuntary treatment or criminal responsibility.
- Differential diagnoses to consider in a patient presenting with paranoid thinking include: normal response to stress; PPD; other personality disorders; delusional disorder; depression; anxiety disorders; schizophrenia and other psychotic disorders.
- The distinction between PPD and delusional disorder is especially challenging.

Psychological processes in paranoia

The various psychosocial processes involved in facilitating paranoid thinking include:

- An externalising, personal attributional bias: a tendency to explain negative events by blaming others rather than reflecting on one’s own potential contribution to circumstances
- Information processing biases and deficits affecting cognitive processing capacity, perceptual processes, empathy and attention
- Exposure to stressful interpersonal situations, particularly those involving novelty, scrutiny, powerlessness or uncertainty
- Hypervigilance and rumination exacerbated by dysphoric self-consciousness
- Various self-perpetuating cycles such as: the difficulty of disproving suspicions; eliciting social exclusion, and the absence of normative, potentially corrective social experiences.

Risk of violence

- Regarding the evidence linking paranoid personality features with risk of aggression, most data relate to populations with mixtures of maladaptive personality features, but paranoid features do appear to make an independent contribution to risk.

- Possible pathways to violence in those with paranoid traits include:
  - Vengeance for perceived slights
  - Perceived challenges to safety or status
  - Suspiciousness eliciting hostile behaviour from others in the environment
  - Disinhibition due to emergent depressive and/or psychotic features.
Treatment

**General principles for the clinician**

- Carefully consider differential diagnosis and comorbidity.
- Have realistic treatment aims.
- Maintain awareness of your own feelings.
- Take special care regarding the patient’s sensitivity to rejection and to authority.
- Take care with boundary management.
- Monitor the patient's mood symptoms.

**Psychotherapy**

- Generally the most useful for PPD is the Beck model of cognitive therapy.
- For severe disorder, psychosocial residential treatment with psychotherapy is recommended.
- Where there is a limited evidence base, individual supportive dynamic psychotherapy and schema therapy can be tried.

**Pharmacotherapy**

- There is no established drug treatment.
- Comorbid conditions should be treated as appropriate.

**Further reading**


