



# ‘They’re out to get me!’:

## Evaluating rational fears and bizarre delusions in paranoia

Paranoid delusions can reveal a number of psychiatric disorders; building trust is key to treatment

### James Allen Wilcox, MD, PhD

Professor of Clinical Psychiatry  
University of Arizona  
Staff Psychiatrist  
Southern Arizona Veterans Administration  
Health Care System  
Tucson, Arizona

### P. Reid Duffy, PhD, RN

Mental Health Research Coordinator  
Southern Arizona Veterans Administration  
Health Care System  
Tucson, Arizona

#### Disclosures

The authors report no financial relationships with any company whose products are mentioned in this article or with manufacturers of competing products.

Even among healthy individuals, feelings of paranoia are not unusual. In modern psychiatry, we consider paranoia to be a pattern of unfounded thinking, centered on the fearful experience of perceived victimization or threat of intentional harm. This means that a patient with paranoia is, by nature, difficult to engage in treatment. A patient might perceive the clinician as attempting to mislead or manipulate him. A therapeutic alliance could require patience on the part of the clinician, creativity,<sup>1</sup> and abandoning attempts at rational “therapeutic” persuasion. The severity of symptoms determines the approach.

In this article, we review the nature of paranoia and the continuum of syndromes to which it is a central feature, as well as treatment approaches.

### Categorization and etiology

Until recently, clinicians considered “paranoid” to be a subtype of schizophrenia (*Box*,<sup>2-7</sup> page 30); in DSM-5 the limited diagnostic stability and reliability of the categorization rendered the distinction obsolete.<sup>8</sup> There are several levels of severity of paranoia; this thought process can present in simple variations of normal fears and concerns or in severe forms, with highly organized delusional systems.

The etiology of paranoia is not clear. Over the years, it has been attributed to defense mechanisms of the ego, habitual fears from repetitive exposure, or irregular activity of the amygdala. It is possible that various types of paranoia could have different causes. Functional MRIs indicate that the amygdala is involved in anxiety and threat perception in both primates and humans.<sup>9</sup>

continued





## Paranoia

### Clinical Point

Perhaps the key to separating realistic fear from paranoia is the recognition of whether the environment is truly safe or hostile



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### Box

## Paranoia: An old term with a new meaning

A variety of paranoid conditions have been described in society for centuries. The term *paranoia* is derived from the Greek “para” (beside) and “noos” (mind). In other words, a condition of mental illness where a preoccupation of the mind occurs.<sup>2</sup> Before the 19th century, the term *paranoia* could be used for almost any form of delusional thinking. In 1863 Kahlbaum used the term *paranoia* to describe chronic delusions of persecution.<sup>3,4</sup> In describing dementia praecox, Kraepelin initially regarded paranoia as a distinct disorder.<sup>5</sup> Bleuler argued that there was no need for distinction between paranoia and his concept of schizophrenia.<sup>6</sup> In 1921, Mayer concluded that paranoid psychosis could not be separated from schizophrenia, based upon phenomenology.<sup>7</sup>

### Rational fear vs paranoia

Under the right circumstances, anyone could sense that he (she) is being threatened. Such feelings are normal in occupied countries and nations at war, and are not pathologic in such contexts. Anxiety about potential danger and harassment under truly oppressive circumstances might be biologically ingrained and have value for survival. It is important to employ cultural sensitivity when distinguishing pathological and non-pathological paranoia because some immigrant populations might have increased prevalence rates but without a true mental illness.<sup>10</sup>

Perhaps the key to separating realistic fear from paranoia is the recognition of whether the environment is truly safe or hostile; sometimes this is not initially evident to the clinician. The first author (J.A.W.) experienced this when discovering that a patient who was thought to be paranoid was indeed being stalked by another patient.

Rapid social change makes sweeping explanations about the range of threats experienced by any one person of limited value. Persons living with serious and persistent mental illness experience stigma—harassment, abuse, disgrace—and, similar to victims of repeated sexual abuse and other violence, are not necessarily unrea-

sonable in their inner experience of omnipresent threat. In addition, advances in surveillance technology, as well as the media proliferation of depictions of vulnerability and threat, can plant generalized doubt of historically trusted individuals and systems. Under conditions of severe social discrimination or life under a totalitarian regime, constant fear for safety and worry about the intentions of others is reasonable. We must remember that during the Cold War many people in Eastern Europe had legitimate concerns that their phones were tapped. There are still many places in the world where the fear of government or of one’s neighbors exists.

In a case of vague paranoia, clinicians must take care in diagnosis and recommending involuntary hospitalization because psychiatric treatment can lead to scapegoating persons for behavior that is not pathological, but merely socially undesirable.<sup>11</sup>

Symptoms of paranoia can take more pathological directions. These 3 psychiatric conditions are:

- paranoid personality disorder
- delusional disorder
- paranoia in schizophrenia (*Table, page 32*).

### Paranoid personality disorder

The nature of any personality disorder is a long-standing psychological and behavioral pattern that differs significantly from the expectations of one’s culture. Such beliefs and behaviors typically are pervasive across most aspects of the individual’s interactions, and these enduring patterns of personality usually are evident by adolescence or young adulthood. Paranoid personality disorder is marked by pervasive distrust of others. Typical features include:

- suspicion about other people’s motives
- sensitivity to criticism
- keeping grudges against alleged offenders.<sup>8</sup>

The patient must have 4 of the following symptoms to confirm the diagnosis:

- suspicion of others and their motives
- reluctance to confide in others, due to lack of trust

- recurrent doubts about the fidelity of a significant other
- preoccupation with doubt regarding trusting others
- seeing threatening meanings behind benign remarks or events
- perception of attacks upon one's character or reputation
- bears persistent grudges.<sup>8</sup>

Individuals with paranoid personality disorder tend to lead maladaptive lifestyles and might present as irritable, unpleasant, and emotionally guarded. Paranoid personality disorder is not a form of delusion, but is a pattern of habitual distrust of others.

The disorder generally is expressed verbally, and is seldom accompanied by hallucinations or unpredictable behavior. Distrust of others might result in social isolation and litigious behavior.<sup>8</sup> Alternately, a patient with this disorder might not present for treatment until later in life after the loss of significant supporting factors, such as the death of parents or loss of steady employment. Examination of these older individuals is likely to reveal long-standing suspiciousness and distrust that previously was hidden by family members. For example, a 68-year-old woman might present saying that she can't trust her daughter, but her recently deceased spouse would not let her discuss the topic outside of the home.

The etiology of paranoid personality disorder is unknown. Family studies suggest a possible genetic connection to paranoia in schizophrenia.<sup>12</sup> Others hypothesize that this dysfunction of personality might originate in early feelings of anxiety and low self-esteem, learned from a controlling, cruel, or sadistic parent; the patient then expects others to reject him (her) as the parent did.<sup>13,14</sup> Such individuals might develop deep-seated distrust of others as a defense mechanism. Under stress, such as during a medical illness, patients could develop brief psychoses. Antipsychotic treatment might be useful in some cases of paranoid personality disorder, but should be limited.

## Delusional disorder

Delusional disorder is a unique form of psychosis. Patients with delusional disorder

might appear rational—as long as they are in independent roles—and their general functioning could go unnoticed. This could change when the delusions predominate their thoughts, or their delusional behavior is unacceptable in a structured environment. Such individuals often suffer from a highly specific delusion fixed on 1 topic. These delusions generally are the only psychotic feature. The most common theme is that of persecution. For example, a person firmly believes he is being followed by foreign agents or by a religious organization, which is blatantly untrue. Another common theme is infidelity.

Paranoia in delusional disorder is about something that is not actually occurring, but could.<sup>3</sup> In other words, the delusion is not necessarily bizarre. The patient may have no evidence or could invent "evidence," yet remain completely resistant to any logical argument against his belief system. In many situations, individuals with delusional disorder function normally in society, until the delusion becomes severe enough to prompt clinical attention.

## Paranoia in schizophrenia

In patients with schizophrenia with paranoia, the typical symptoms of disorganization and disturbed affect are less prominent. The condition develops in young adulthood, but could start at any age. Its course typically is chronic and requires psychiatric treatment; the patient may require hospital care.

Although patients with delusional disorder and those with schizophrenia both have delusions, the delusions of the latter typically are bizarre and unlikely to be possible. For example, the patient might believe that her body has been replaced with the inner workings of an alien being or a robot. The paranoid delusions of persons with delusional disorder are much more mundane and could be plausible. Karl Jaspers, a clinician and researcher in the early 20th century, separated delusional disorder from paranoid schizophrenia by noting that the former could be "understandable, even if untrue" while the latter was "not within the realm of understandability."<sup>5</sup>

## Clinical Point

**Paranoia in delusional disorder is about something that is not actually occurring, but could**



## Paranoia

### Clinical Point

Persons with dementia often are paranoid; a delusion of thievery is common

### Table

## Differentiating 3 disorders with paranoia as a key feature

<b>Paranoid personality disorder</b>	<p>Pervasive feelings of distrust</p> <p>Might lack delusions, but the patient still feels that people are acting maliciously and cannot be trusted</p> <p>Might believe in conspiracy theories or feel that he (she) is the target of ill will. These patients often are litigious and unhappy</p> <p>Usually there is no evidence of overt psychosis. Antipsychotics might be helpful if the patient is willing to take them; cognitive-behavioral therapy could be effective in patients with intact insight</p>
<b>Delusional disorder</b>	<p>Persistent false beliefs of persecution</p> <p>Delusions often are about finances or marital fidelity</p> <p>The beliefs might appear possible, but are not based on fact</p> <p>Hallucinations do not usually occur and the delusions are never bizarre</p> <p>A combination of antipsychotic medication and cognitive therapy might be useful</p>
<b>Schizophrenia with paranoid features</b>	<p>Patients are quite disturbed; they often have bizarre persecutory delusions that are unlikely to be possible</p> <p>Auditory hallucinations are common</p> <p>Treatment with antipsychotic medication often is successful, but poor insight causes compliance issues</p>

A patient with schizophrenia with paranoid delusions usually experiences auditory hallucinations, such as voices threatening persecution or harm. When predominant, patients could be aroused by these fears and can be dangerous to others.<sup>2,4,5</sup>

### Other presentations of paranoia

Paranoia can occur in affective disorders as well.<sup>13</sup> Although the cause is only now being understood, clinicians have put forth theories for many years. A depressed person might suffer from excessive guilt and feel that he deserves to be persecuted, while a manic patient might think she is being persecuted for her greatness. In the past, response to electroconvulsive therapy was used to distinguish affective paranoia from other types.<sup>2</sup>

### Paranoia in organic states

**Substance use.** Psychostimulants, which are known for their motor activity and arousal enhancing properties, as well as the potential for abuse and other negative consequences, could lead to acute paranoid states in susceptible individuals.<sup>15-17</sup> In addition, tetrahydrocannabinol, the active chemical in *Cannabis*, can cause acute psy-

chotic symptoms, such as paranoia,<sup>18,19</sup> in a dose-dependent manner. A growing body of evidence suggests that a combination of *Cannabis* use with a genetic predisposition to psychosis may put some individuals at high risk of decompensation.<sup>19</sup> Of growing concern is the evidence that synthetic cannabinoids, which are among the most commonly used new psychoactive substances, could be associated with psychosis, including paranoia.<sup>20</sup>

**Dementia.** Persons with dementia often are paranoid. In geriatric patients with dementia, a delusion of thievery is common. When a person has misplaced objects and can't remember where, the "default" cognition is that someone has taken them. This confabulation may progress to a persistent paranoia and can be draining on caregivers.

### Treating paranoia

A patient with paranoia usually has poor insight and cannot be reasoned with. Such individuals are quick to incorporate others into their delusional theories and easily develop notions of conspiracy. In acute psychosis, when the patient presents with fixed beliefs that are not amenable to reality orientation, and poses a threat to his well-

being or that of others, alleviating underlying fear and anxiety is the first priority. Swift pharmacologic measures are required to decrease the patient's underlying anxiety or anger, before you can try to earn his trust.

Psychopharmacologic interventions should be specific to the diagnosis. Antipsychotic medications generally will help decrease most paranoia, but affective syndromes usually require lithium or divalproex for best results.<sup>14,21</sup>

**Develop a therapeutic relationship.** The clinician must approach the patient in a practical and straightforward manner, and should not expect a quick therapeutic alliance. Transference and countertransference develop easily in the context of paranoia. Focus on behaviors that are problematic for the patient or the milieu, such as to ensure a safe environment. The patient needs to be aware of how he could come across to others. Clear feedback about behavior, such as "I cannot really listen to you when you're yelling," may be effective. It might be unwise to confront delusional paranoia in an agitated patient. Honesty and respect must continue in all communications to build trust. During assessment of a paranoid individual, evaluate the level of dangerousness. Ask your patient if he feels like acting on his beliefs or harming the people that are the targets of his paranoia.

As the patient begins to manage his anxiety and fear, you can develop a therapeutic alliance. The goals of treatment need be those of the patient—such as staying out of the hospital, or behaving in a manner that is required for employment. Over time, work toward growing the patient's capacity for social interaction and productive activity. Insight might be elusive; however,

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## Related Resources

- Freeman D. Persecutory delusions: a cognitive perspective on understanding and treatment. *Lancet Psychiatry*. 2016;3(7):685-692.
- Skelton M, Khokhar WA, Thacker SP. Treatments for delusional disorder. *Cochrane Database Syst Rev*. 2015;(5):CD009785. doi: 10.1002/14651858.CD009785.pub2.

### Drug Brand Names

Divalproex • Depakote      Lithium • Eskalith, Lithobid

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some patients with paranoia can learn to take a detached view of their thoughts and emotions, and consider them impermanent events of the mind that make their lives difficult. Practice good judgment when aiming for recovery in a patient who does not have insight. For example, a patient can recognize that although there could be a microchip in his brain, he feels better when he takes medication.

In the case of paranoid personality disorder, treatment, as with most personality disorders, can be difficult. The patient might be unlikely to accept help and could distrust caregivers. Cognitive-behavioral therapy could be useful, if the patient can be engaged in the therapeutic process. Although it might be difficult to obtain enhanced insight, the patient could accept logical explanations for situations that provoke distrust. As long as anxiety and anger can be kept under control, the individual might learn the value of adopting the lessons of therapy. Pharmacological treatments are aimed at reducing the anxiety and anger experienced by the paranoid individual. Antipsychotics may be useful for short periods or during a crisis.<sup>14,21</sup>

The clinician must remain calm and reassuring when approaching an individual with paranoia, and not react to the projection of

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## Bottom Line

Paranoia can be a feature of paranoid personality disorder, delusional disorder, or schizophrenia, as well as substance abuse or dementia. Determining whether the paranoid delusion is bizarre or plausible guides diagnosis. Patients with paranoia typically have poor insight and are difficult to engage in treatment. Pharmacotherapy should be specific to the diagnosis. Establishing a consistent therapeutic relationship is essential.

### Clinical Point

**The clinician must approach the patient in a practical and straightforward manner, and should not expect a quick therapeutic alliance**

## Paranoia

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paranoid feelings from the patient. Respect for the patient can be conveyed without agreeing with delusions or bizarre thinking. The clinician must keep agreements and appointments with the client to prevent the erosion of trust. Paranoid conditions might respond slowly to pharmacological treatment, therefore establishing a consistent therapeutic relationship is essential.

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