

Personality Disorders- Paranoid Personality Disorder

DSM-IV-TR Diagnostic Code: 301.00 Paranoid Personality Disorder

Diagnostic Guidelines:

1. Establish diagnostic accuracy as defined in DSM-IV-TR/ICD-9.
2. Identify differential diagnoses and co-morbid problems: rule out delusional disorders, schizophrenia, mood disorders with psychotic features, substance related disorders, Personality Change Due to a General Medical Condition, and other personality disorders. Use psychological testing to assist with rule outs when treatment based on standard clinical evaluation and treatment approaches is ineffective, or fails to improve the client's mental status and related functioning. A multi-pronged assessment approach that utilizes both objective and projective measures may be most effective in differentiating Paranoid Personality Disorders from other types of psychopathology.
3. Establish accurate diagnosis through continued assessment of behavior over time, and rule out of other diagnoses as necessary. Individuals with significant personality disorder symptoms often experience difficulties in sustaining employment, establishing and/or maintaining relationships, and other important life spheres. There also may be an associated history of difficulties with the law or with other authority figures. Exaggerated mistrust and suspiciousness of others is the hallmark symptom of Paranoid Personality Disorder.
4. Obtain external corroboration of diagnosis when possible through review of past treatment history, legal history, etc.
5. Review previous treatment episodes to determine efficacy of treatment interventions and therapeutic gains. Individuals with a primary diagnosis of Paranoid Personality Disorder are unlikely to seek treatment voluntarily. Often, individuals with Paranoid Personality Disorder are mandated to attend treatment, or they might seek treatment when these primary defenses fail and they experience symptoms of depression and/or anxiety.

Treatment Guidelines

1. As noted above, individuals with a primary diagnosis of Paranoid Personality Disorder rarely present themselves for treatment. As a result, there has been little outcome research to suggest which types of treatment are most effective with this disorder. It is likely that a therapy, which emphasizes a simple, supportive, client-centered approach, will be most effective. Rapport-building with a person who

- has this disorder may be much more difficult than usual because of the paranoia associated with the disorder. Early, unplanned termination is common.
2. During times when the client is acting upon his paranoid beliefs, the clinician's loyalties and trust may be called into question. The clinician must be careful not to challenge the client too firmly, possibly provoking the individual into leaving therapy. At times, the paranoid patient's behavior may become so threatening that it is important to control it or set limits on it. Delusional accusations must be dealt with realistically but gently, and without humiliating the patient. Control issues should be dealt with in a similar manner. Since the paranoid beliefs are delusional, and not based in reality, disputing them from a rational point of view is seldom useful. Challenging the beliefs is also likely to result in more frustration for both the clinician and client.
 3. Clinicians working with individuals with this disorder should be more keenly aware of being straight-forward. Jokes are often missed, and information about the client not received directly from the client will raise a great deal of suspicion.
 4. An honest, concrete approach will likely gain the best results, focusing on current life difficulties which have brought the client into therapy. Clinicians should generally not inquire too deeply into the client's life or history, unless it is directly relevant to clinical treatment.
 5. Medications are usually contraindicated for this disorder, since they can arouse unnecessary suspicion that will usually result in noncompliance and discontinuation of treatment. Medications prescribed for specific symptoms should be for brief periods of time to bring the symptoms under control. An anti-anxiety agent may be appropriate to prescribe if the client suffers from severe anxiety or agitation that interferes with normal, daily functioning. An anti-psychotic medication may be appropriate if a client decompensates into severe agitation or delusional thinking, which may result in self-harm or harm to others.
 6. Group or family therapy is not recommended because a person with this disorder is likely to be mistrustful and suspicious of others and their motivations, making group help and dynamics unlikely and possibly harmful.
 7. Long-term prognosis for this disorder is generally poor. Individuals who suffer from this disorder often remain afflicted with prominent symptoms throughout their lifetime. It is not uncommon to see such people in day treatment programs or state hospitals.

References:

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