CASE REPORT

Paranoid Personality Disorder

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Since the time of Kraepelin, a pervasive and unwarranted mistrust of others has been considered a cardinal feature of paranoid personality disorder. Other features that have been described prominently in the literature are sensitivity to criticism, aggressiveness, rigidity, hypervigilance, and an excessive need for autonomy. We present the case of a patient with most of these classic characteristics that represent key components of the diagnostic criteria for paranoid personality disorder in the DSM-5 (Table 1).

CASE

"Mr. J" is a 65-year-old Caucasian man with no prior psychiatric history, history of chronic obstructive pulmonary disease, and a benign vocal cord lesion. He was brought to the emergency department by police for concerns of psychosis and delusions. Records stated that the "patient is delusional, in a state of acute psychosis, easily agitated."

Upon initial contact with the emergency department psychiatrist, the patient reported feeling that the staff at the hospital were against him. He reported never having seen a psychiatrist before, although he reported having been on a selective serotonin reuptake inhibitor in the past to help equilibrate his "serotonin levels." He did not fully cooperate with the interview, was guarded and evasive, and often said, "You don't need to know." His mental status examination was notable for disorganized process and paranoid content. During the latter part of the assessment, the patient became loud, intrusive, and agitated. He pounded his cane on the ground and threw it to the floor in a threatening manner.

He requested discharge but would not elaborate on a safe discharge plan nor allow his family to be contacted. He declined voluntary inpatient hospitalization and threatened to sue the emergency department psychiatrist if he were to be involuntarily committed.

The patient was involuntarily admitted to the inpatient unit due to aggressive behavior and risk of harm to others. He remained at the hospital for 15 days. During the initial part of his stay, he was easily agitated, displayed verbal aggression, exhibited paranoia, and refused treatment. He would not engage in conversation with most team members, with the exception of a medical student on the team to whom he reported paranoid ideations about various family members and friends. He was suspicious and mistrustful of the treatment providers and mostly focused his conversations on legal issues. He claimed that he was being held in the hospital illegally and threatened to sue the providers for holding him against his will.

He reported being estranged from most of his family since his wife's death. He stated that his daughters "did not understand him." Very reluctantly, he gave permission for one of his daughters to be contacted. His daughter described him as always being an "eccentric and distrustful person." She described incidents in the past in which he had held beliefs about others "being against" him, resulting in isolation from friends and family. She described him as someone who "often held grudges and for a long time." She reported a chronic pattern of behavioral problems, aggression, strained relationships, and suspicious thinking. She also described his behavior as worsening recently. Additionally, the patient reported increasing use of cannabis and synthetic cannabinoids over the past few years; indeed,

TABLE 1. DSM-5 Criteria for Paranoid Personality Disorder[a]

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
4. Reads hidden demeaning or threatening meanings into benign remarks or events.
5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).
6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.
7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or a depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

[a] If criteria are met prior to the onset of schizophrenia, add "premorbid," i.e., "paranoid personality disorder (premorbid). Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (Copyright ©2013). American Psychiatric Association. All Rights Reserved.

the frankly disorganized thought process he displayed during his emergency department assessment and the initial part of his hospital stay was most consistent with intoxication in that it resolved early on without medication, but his paranoia lingered.

Mr. J continued to refuse treatment, and thus a medication commitment was pursued. Following court approval, he was started on olanzapine (10 mg q.h.s.) and gradually uptitrated (to 20 mg q.h.s.). He subsequently remained medication compliant and tolerated the medication well while showing gradual improvement in his disorganized thought process. Initially, he displayed angry outbursts that precluded meaningful discussions about discharge planning. However, he eventually became calm enough to develop a safe discharge plan. At the time of discharge, he was calm and cooperative and denied all psychiatric symptoms. Nevertheless, he continued to be mistrustful of providers and continued to report paranoid ideations about family members. The patient's final diagnosis was cannabis-induced psychosis with intoxication, with underlying paranoid personality disorder.

DISCUSSION

Paranoid personality disorder, though a chronic condition, is not commonly encountered in the clinical setting. The prevalence of paranoid personality disorder indicates that it is among the most common personality disorders, with recent estimates varying from 2.4% (1) to 4.41% (2). In 1921, Kraepelin first proposed three distinct presentations of paranoia that correspond to the diagnoses of schizophrenia, delusional disorder, and paranoid personality disorder (3). However, Kraepelin considered paranoid personality disorder phenomena to represent part of the schizophrenia spectrum, since these patients often later decompensated into frank psychosis (4). Paranoid personality disorder first appeared in DSM-III in 1980.

Paranoid personality disorder is a statistically significant predictor of disability (2) and is also associated with both violence and criminal behavior (5). Reports of comorbidities have varied widely, with panic disorder with agoraphobia recognized as a common comorbid psychiatric disorder (6). Regarding personality disorder pathology, schizotypal, narcissistic, borderline, and avoidant personality disorder traits are commonly comorbid with paranoid personality disorder, and indeed there is some overlap of diagnostic criteria with those disorders and paranoid personality disorder (6).

Paranoia in paranoid personality disorder does not represent delusional psychosis but rather a "distinctly paranoid cognitive style" (7). Individuals with paranoid personality disorder rarely seek treatment on their own accord but may do so at the behest of family or coworkers (8). The nature of their disturbance is not conducive to perceiving their own pathology, and their treatment may ultimately be burdened by their mistrust of physicians.

Because paranoid personality disorder patients are unlikely to seek or remain in psychiatric care, relevant treatments for this disorder have received less research relative to those of similarly prevalent personality disorders. There are no Food and Drug Administration-approved medications for paranoid personality disorder. A Cochrane Review of pharmacological interventions for paranoid personality disorder is currently underway (4). Much of the published literature takes the form of case studies or case series. One such case report found cognitive analytic therapy to be an effective intervention (8), while another suggested that in the short-term, the use of antipsychotics in patients with paranoid personality disorder was associated with improved Clinical Global Impression scores (9). Cognitive therapy has been endorsed as a useful technique for the general psychiatrist (10). Recommended approaches to psychodynamic psychotherapy for these patients include working toward helping patients "shift their perceptions of the origin of their problems from an external locus to an internal one" (8), while maintaining special attention to management of boundaries, maintenance of the therapeutic alliance, safety, and awareness of how the therapy may be integrated into the patient's paranoid stance. In the case of the patient feeling paranoid toward the therapist, aiding the patient in saving face and maintaining a sense of control may be particularly important in preventing escalation to violence toward the therapist (8).

In the above case, our patient presented as paranoid and lacking insight; collateral was required to establish the chronic course of his paranoia. He had, until late in his life, not been involved in psychiatric care. Interestingly, he did seek evaluation for memory problems (fearing he had dementia) sometime after discharge; findings were not consistent with dementia, and he expressed that his chronic cannabis exposure may be the cause of his cognitive problems.

CONCLUSIONS

The diagnosis of paranoid personality disorder involves rigorous assessment and may require collateral. Given the condition's prevalence, the disabling nature of the illness, and the potential for loss of quality of life for the patient, as well as violence toward others, evidence-based treatments for optimal management of paranoid personality

KEY POINTS/CLINICAL PEARLS

- Paranoid personality disorder is one of the more prevalent personality disorders but not commonly encountered in clinical settings.
- Paranoid personality disorder is a predictor of disability and is associated with violence and criminal behavior.
- There are no Food and Drug Administration-approved medications for paranoid personality disorder.
- Cognitive-behavioral therapy and psychodynamic therapy have been shown to be effective treatment modalities.

disorder have the potential to benefit not only sufferers of paranoid personality disorder but society as well. Future research is needed to further explore potential treatments for this prevalent and debilitating condition.

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