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Challenges of Treatment and Living with the Stigma Related to Paranoid Personality Disorder



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ABSTRACT

Background: Paranoid personality disorder (PPD) is characterized by inflexible distrust and suspiciousness of others not supported by evidence. They fear others are out to get them. Stigma related to this disorder includes being labeled as mistrustful and misunderstood. This is not a new addition to the Diagnostic and Statistical Manual; however, adequate research is lacking. **Purpose:** This paper aims to address the stigma of the diagnosis PPD, challenges patients face, and to recognize the challenges of treatment for this disorder. **Method:** This literature review examines studies on PPD and assessing the contributing factors for the diagnosis, along with analyzing a case study. It discusses challenges faced by health care providers for providing treatment. **Conclusion:** Currently there are no Food and Drug Administration (FDA) approved medications for the treatment of PPD. People with this disorder tend to refuse treatment. Interventions to help individuals during an inpatient stay include opening medications in front of the individual and providing pre-packaged foods. Careful diagnosis is vital for individuals to receive any help. Antianxiety, antidepressants, and antipsychotics may be helpful in subsiding symptoms.

INTRODUCTION

Personality disorders are diagnosed when disruption in daily activities or distress occurs from a change in cognition, emotion, and behavior. Personality disorders are included in the most commonly diagnosed psychiatric conditions [1]. PPD is characterized by suspiciousness and unprovoked distrust [2] and ranks as the fourth most common personality disorder at 1.9% [1]. PPD is associated with substance use, poor socialization, and role dysfunction [2]. Challenges are faced for individuals diagnosed with PPD in the form of stigma, treatment challenges. The purpose of this paper is to address the stigma, challenges patients face, and to recognize the challenges of treatment for PPD.

BACKGROUND

The cardinal feature of PPD is unwarranted mistrust of others based on the unwarranted belief others want to exploit or harm them. In the psychiatric classification, DSM-5 describes PPD as a disorder of suspicious, unforgiving, ruminative, and jealous traits [3]. Other characteristics patients with PPD exhibit include hypervigilance, aggression, rigidity, excessive need for autonomy, and sensitivity to criticism initiating counterattacks [4]. Patients with PPD often use the defense mechanism of projection, attributing blame onto others for their own internal sufferings [5]. Excessive mistrust is an obstacle in healthcare. Patients with PPD tend to neglect healthcare related to their mistrust of others including healthcare personnel [4].

A review was conducted through The University of Chicago Department of Psychiatry and Behavioral Neuroscience to provide an update on what is known on the historically misunderstood clinical problem of PPD [6]. Science has neglected PPD research related to its history of negative clinical outcomes. Historically PPD was linked with schizophrenia due to the similarity in paranoid delusions. PPD tends to be clinically overlooked because symptoms may be accounted for by diagnoses of other personality disorders. PPD has not been a priority for research funding, though it is a relatively common, severe clinical problem. PPD understanding is improving as further research accrues [6].

CASE STUDY

Vyas and Khan [4] described the story of Mr. J, a patient who was displaying strange behaviors. Mr. J was a 65-year-old Caucasian man with no prior psychiatric history. He was

escorted to the emergency department by police officials stating they found him and had concerns of psychosis, extreme agitation, and delusions. Upon initial encounter with the emergency department psychiatrist, Mr. J. expressed the hospital staff was against him. Mr. J. reported he had never seen a psychiatrist during his lifetime. However, he admitted to previously being prescribed selective serotonin inhibitors (SSRIs). He was noncooperative in the interview and often responded with, “You don’t need to know.” His mental status examination suggested a disorganized thought process and paranoia. Towards the end of the psychiatric assessment, the patient became increasingly agitated even throwing his cane on the ground in a threatening manner.

At this time Mr. J requested discharge but would not allow his family to be contacted or cooperate to form a safe discharge plan. He declined voluntary inpatient treatment and threatened to sue the psychiatrist if he was kept involuntarily. Nonetheless, Mr. J was committed involuntarily because his aggressive behavior posed harm to others. He was committed for 15 days and exhibited agitation, aggression, and paranoia. Mr. J opted to minimally engage in conversation while committed, except for one medical student to whom he reported suspicions of other medical personnel and his own family. He focused his conversations with providers on legal issues and his threats to sue for being held against his will. He claimed to be estranged from his family since his wife’s death stating his daughters did not understand him.

When Mr. J reluctantly allowed for one of his daughters to be contacted, she reported he has always been “eccentric and distrustful.” She proclaimed he had always thought others were out to get him resulting in estrangement from friends and family. She reported chronic behavior problems of aggression, suspicion, and strained relationships. Though, she reported his behavior had been worsening recently. Mr. J reported increased cannabis use within the last few years. The disorganized thinking the patient presented to the emergency department with was consistent with intoxication and subsided without medication, however, the paranoia remained. Mr. J’s final diagnosis was *cannabis-induced psychosis with intoxication, with underlying PPD*.

Mr. J continued to refuse treatment and therefore an antipsychotic was court-ordered. He was then complainant and tolerated the medication well showing behavioral improvement. He finally cooperated enough to form a safe discharge plan and was calm and cooperative at the

time of discharge. Mr. J still reports distrust among healthcare personnel and suspicion of family members.

Mr. J's behavior characteristics are a prime example of struggles patients with PPD face daily. Patients with PPD are at constant risk for isolation related to their immense mistrust for others. The disorder characteristics cause strain on personal relationships as well as therapeutic relationships with medical personnel putting their health at risk. These patients face a constant battle every day on how to live in a world where everyone is seemingly intending to harm them.

REVIEW OF THE LITERATURE

In hopes of addressing the challenges of PPD, this paper reviews the literature on stigma in PPD, contributing factors such as race, socioeconomic status, and cultural beliefs, and the challenges of treatment. Using the university library online article search, Google Scholar, CINAHL Complete, and PubMed, articles were found by using the keywords *paranoia*, *personality disorders*, and *paranoid personality disorder*.

The South Bay National Alliance on Mental Illness addresses paranoia and PPD specifically stating PPD is characterized by having a “long-standing pattern of pervasive distrust and suspiciousness of other” [7]. It also stated that a person with PPD will always question others motives and assume the motives are evil. This provides challenges for treatment.

PPD is among the least studied personality disorder with few studies completed in comparison to other personality disorders despite its fairly common occurrence. There is little to no neurobiological, somatic, or psychotherapeutic treatment studies conducted or published for PPD. PPD is associated with lower quality of life but lacks research to support treatment options. This could be because of lack of attention given to PPD since individuals with paranoia may be the most difficult to engage in studies or the ambivalence of the characteristics of the disorders since many personality disorders display signs of paranoia. Paranoia is a common characteristic among other disorders such as borderline personality disorder (BPD), post-traumatic stress disorder (PTSD), and schizophrenia [8].

Psychopathology of Paranoia

Freud's theory suggests paranoia is an unconscious defense from internal homosexual desires. Scant evidence has been found to support the idea paranoia arises from homosexual urges. However, research supports the idea of paranoia as an external projection of internal conflict [6]. Projection is the most common defense mechanism observed in patients with PPD [5].

Psychoanalyst, Otto Kernberg, theorized PPD as a lower order subtype of BPD characterized by excessive aggressive drives and primitive mental processes such as splitting [6]. Splitting is the inability to view the positive and negative aspects of a person as a whole; it is the thought a person is either good or bad [5]. The psychological process of splitting is thought to arise from early life trauma [6].

Cognitive theories of PPD stress a relationship between low self-esteem and paranoia. Psychiatrist, Aaron Beck, argues patients with PPD suffer from low self-esteem seeing themselves as lacking efficacy and others as malicious and deceitful. This distorted view of others leads to excessive guardedness, emotional instability, and fear of being vulnerable. Cognitive theories argue self-deficiency is the core of PPD [6].

Stigma

The label of "personality disorder" is stigmatizing and can further complicate the diagnosis of PPD but is necessary to receive treatment [9]. PPD has been classified under cluster A personality disorder in addition to schizoid and schizotypal personality disorders. Diagnosed with a personality disorder places an individual at risk for self-harm, abuse substances, and other psychiatric problems [10].

Public knowledge is lacking regarding personality disorders because individuals may be viewed as misbehaving rather than having a mental illness. Employers, families, and the public may have a misconception of mental illnesses. Employers may view individuals diagnosed with a mental illness as incompetent to perform a job and may even avoid hiring the individual. Media portrays mental illnesses as dangerous by exaggerating mental illness and violence rates and lead the public to fear individuals experiencing them. The common public's view on personality disorders is lacking in comparison to other psychiatric disorder and leads to a belief that individuals should be able to control their own behavior and that

they may be misbehaving rather than experiencing a mental illness. The stigma that hangs over those diagnosed with a mental illness can lead them to have lower self-esteem and some may not seek treatment in fear of being thought of as “crazy” [10].

Stigma reduces the quality and number of services available as well as discourages individuals from seeking out treatment. Since negative provider attitudes can lead to a discrepancy in treatment, it is important to address it to lower the stigma. It is suggested that stigma-changing interventions alongside positive messages for recovery can reduce stigma. Education is one attempt to lower the stigma attached to personality disorders by correcting misunderstandings of mental illnesses. Individuals experiencing stigma meeting together to discuss their experiences is another way to promote a sense of connection to others facing the same challenges. Anti-stigma training can help lower the stigma that individuals feel providers have toward them [10].

Contributing Factors

Factors influencing PPD include race, cultural belief, socioeconomic status, traumatic childhood events, and drug use. It is pertinent that nurses understand and recognize these factors and acknowledge their effect on a patient's diagnosis. Outcomes must be individualized for each patient.

Race

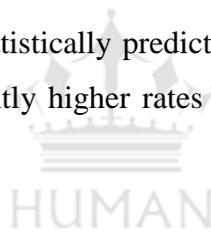
In a study completed at the University of Kentucky, researchers found that African-American men are more likely to be diagnosed with PPD as opposed to their white male counterparts [11]. This diagnosis may be misleading once social contributors are assessed. The study provided quotes and numerical data to support that African-American men may have been socially shaped to become paranoid and this may extend into a diagnosis of PPD [11].

The stigma behind race coupled with the stigma of mental illness provides a risk for misdiagnosis and mistreatment of not only African-American males but other underrepresented groups. This study suggested traits of PPD such as mistrust may be more prominent in black males because of the social situations they endure. One participant mentioned that he believes law enforcement officers target African-American males more than Caucasian males and now this participant does not trust the police and feels that they are not there to protect him but to hurt him [11]. This serves as a major social issue because if

these individuals are not receiving the proper treatment it puts them at risk for harm and further social isolation, which only exacerbates the paranoia phenomenon. It is important to view each patient holistically and include psychosocial factors while assessing for and diagnosing PPD.

Another study assessed if diagnostic discrepancies occur with PPD since differences occur with schizophrenia in regard to race. Symptoms of schizophrenia and PPD belong in the same cluster of personality disorders, but little research has been conducted on PPD in comparison to schizophrenia. One of the challenges with diagnosing PPD is considering whether paranoia symptoms are culturally appropriate in situations or if the symptoms meet the criteria [1].

One hundred and eighty individuals participated in a study to assess PPD symptoms and differences in individuals diagnosed. Fifty-six percent of the participants identified as Black, and the remaining 40% identified as White. Race, drug use, and income were predicted to aid in the diagnosis of PPD. Results indicated race contributed to a diagnosis of PPD whereas substance use and income did not statistically predict a diagnosis of PPD. Those who self-identified as Black showed significantly higher rates of diagnosis of PPD than their White counterparts [1].



Cultural Beliefs

It is essential to take cultural beliefs into consideration when assessing paranoia symptoms to prevent misdiagnosis. Individuals from Africa and Jamaica who had supernatural beliefs have been linked to increasing paranoia levels in comparison to their English counterparts. DSM-5 cautions to pay special attention to cultural beliefs to not mistake thoughts of supernatural forces for paranoia symptoms and may lead to misdiagnosis of PPD [1].

Socioeconomic Status

Evidence suggests that PPD symptoms are related to environmental and cultural factors and Blacks are more likely to experience negative environmental and cultural factors such as victimization and interpersonal and cultural mistrust. One study was conducted to study to assess socioeconomic status, childhood trauma, and race as contributing factors in PPD. Seven hundred and eleven individuals participated in this study with 25% self-identifying as Black and the other 75% self-identifying as White. Socioeconomic status was assessed

through the mean scores of parent's education, participant education, and annual household income. Traumatic events were measured with a self-reported questionnaire. The results showed a correlation between socioeconomic status, childhood trauma, and PPD symptoms. Blacks showed greater PPD mean scores, a higher number of traumatic childhood events, lower levels of education, lower annual household income, and lower parent education than Whites. It is suggested that the findings in the racial difference in PPD are influenced by social inequalities [2].

Traumatic Childhood Events

Childhood trauma is a predictor of PPD alongside race and socioeconomic status. Trauma in childhood is suggested to lead to PPD symptoms, especially in Black individuals [2]. PPD was associated with childhood physical, sexual, and emotional abuse more than any other personality disorder. Childhood victimization fosters paranoia in adolescence, which can lead to PPD [8]. An audit of trauma histories of patients receiving personality disorder treatment at Rampton Hospital, United Kingdom, found that all 77 patients with available data had reported experiencing developmental trauma in their childhood [9].

Drug Use

Illicit drug use has been associated with perceived discrimination. It has been suggested that illicit drug use, cannabis specifically, increases the risk of experiencing psychotic symptoms, but other factors may contribute to the symptoms as well. Illicit drug use can influence an individual's diagnosis of PPD [1]. The case study with Mr. J suggests the possibility of cannabis impacting his diagnosis of PPD.

INTERVENTIONS

Personality disorders are characterized by individuals being especially withdrawn, anti-social, and having odd or unusual thoughts. Currently, there is no specific treatment for personality disorders, including PPD. Given the close relationship between diagnoses, clinicians can use similarities between them to help guide in medication options. For example, PPD is on the schizophrenia spectrum; therefore, in using the data on medication success on schizophrenia, clinicians can predict an impact those drugs will have on a similar diagnosis such as PPD [12].

Studies have shown that taking selective serotonin reuptake inhibitors (SSRI) have increased cooperation in patients diagnosed with PPD and additionally reduced hostile behavior [12]. Given this data, it can be inferred that the use of certain medications indicated for depression has a positive impact on symptoms of personality disorders. Personality disorders can be debilitating to social interaction and relationship building and the positive outcomes of the above medications show a new light in the treatment and management of PPD and personality disorders as a whole.

TREATMENT

An upwards of 30% of individuals who suffer from a mental illness and seek treatment also have a personality disorder [13]. This additional diagnosis makes it difficult for individuals to accept and adapt to treatment regimens and this population tends to struggle with adherence to therapy sessions and recommendations. This issue stems from the characteristics of distrust and the overwhelming inability to get along with others. Therefore, while to others it may seem as if these individuals do not want to seek help, it is their diagnosis that is preventing them from doing so [13].

The complications an individual with a personality disorder experiences will not subside without intervention from professional help [13]. Of the individuals suffering from a personality disorder who do seek treatment, an average of 70% withdraw from the treatment regimen; therefore, contributing to the everlasting cycle of personality disorder management. However, there is new light on the horizon for the treatment of personality disorders. Options such as dialectical behavior training (DBT) and cognitive behavior therapy (CBT) are being introduced and are showing success in patients suffering from personality disorders. These therapies allow patients to understand their disorder and the way it presents itself in a different light and additionally is educated by therapists on new, positive ways to express their emotions. These therapies also allow researchers and clinicians to understand personality disorders in a different light [13].

In the event patients do seek psychiatric care, it is usually in response to family or employer request. Patients suffering from this disorder tend to be very suspicious in clinical settings on why evaluation is happening. Upon assessment, patients with PPD are hard to interview because they fear the information will be used against them. Even when patients are in a facility, they still tend to reject treatment [6].

Patients' reluctance to seek psychiatric care poses a research obstacle. Because patients with PPD are so unwilling to trust medical personnel or participate in research, fewer studies have been conducted on relevant treatments opposed to other personality disorders. Currently, there are no Food and Drug Administration (FDA) approved medications for the treatment of PPD [6]. Pharmacological therapy instead is used as symptom management in patients with PPD. Antianxiety agents may be used to suppress anxiety and agitation. Antipsychotic medications may be necessary in small doses to treat more severe episodes of agitation and delusions. It is suggested the first-generation antipsychotic pimozide is useful in controlling paranoid ideation (Halter, 2018). A Cochrane review is currently being conducted to assess the effectiveness of pharmacological treatment in PPD [14].

Providing care for patients suffering from PPD is an obstacle for medical professionals as therapeutic relationships are difficult to form. Providers should expect accusations, belittling comments, and threats from patients suffering from this disorder [14]. Schedules should be strictly adhered to related to patients' mistrust and suspiciousness. Clear, straightforward explanations should be given to patients avoiding being too nice as they may perceive excessive kindness to be suspicious. Limit the environmental setting when aggressive behaviors are present [5]. Medications should be opened in front of patients to decrease suspicion. Pre-packaged foods are an alternative option if the patient is suspicious of poison. These are appropriate interventions to decrease exacerbation of symptoms when caring for patients with PPD.

DISCUSSION

After reviewing the literature, the proposal that additional research is needed on PPD is said to be true. Challenges and potential intervention for patients with PPD are listed in Figure 1. Patient's diagnosed with PPD are shown to have higher rates of childhood trauma, a lower socioeconomic status, and low self-esteem. These individuals often are hesitant to accept care based on the psychopathology of their disease. Additionally, these individuals face challenges when creating and maintaining relationships. Based on the literature, nurses caring for patients with PPD should maintain a neutral affect when communicating with this population as being "too nice" could trigger paranoia. In addition, a structured routine should be maintained so patients with PPD can establish trust with staff. Limiting the number of staff members working with a particular client on the unit is another nursing intervention supported by evidence. Medication use in the treatment of PPD is still being studied;

however, medications used to treat other psychiatric disorders are showing success in symptom management of PPD. Therapies such as DBT and CBT have also been shown to indicate improvement of the symptoms of PPD. Outcomes include creating and maintaining trusting relationships, establishing positive coping mechanisms, increased self-esteem, and improved symptom management.



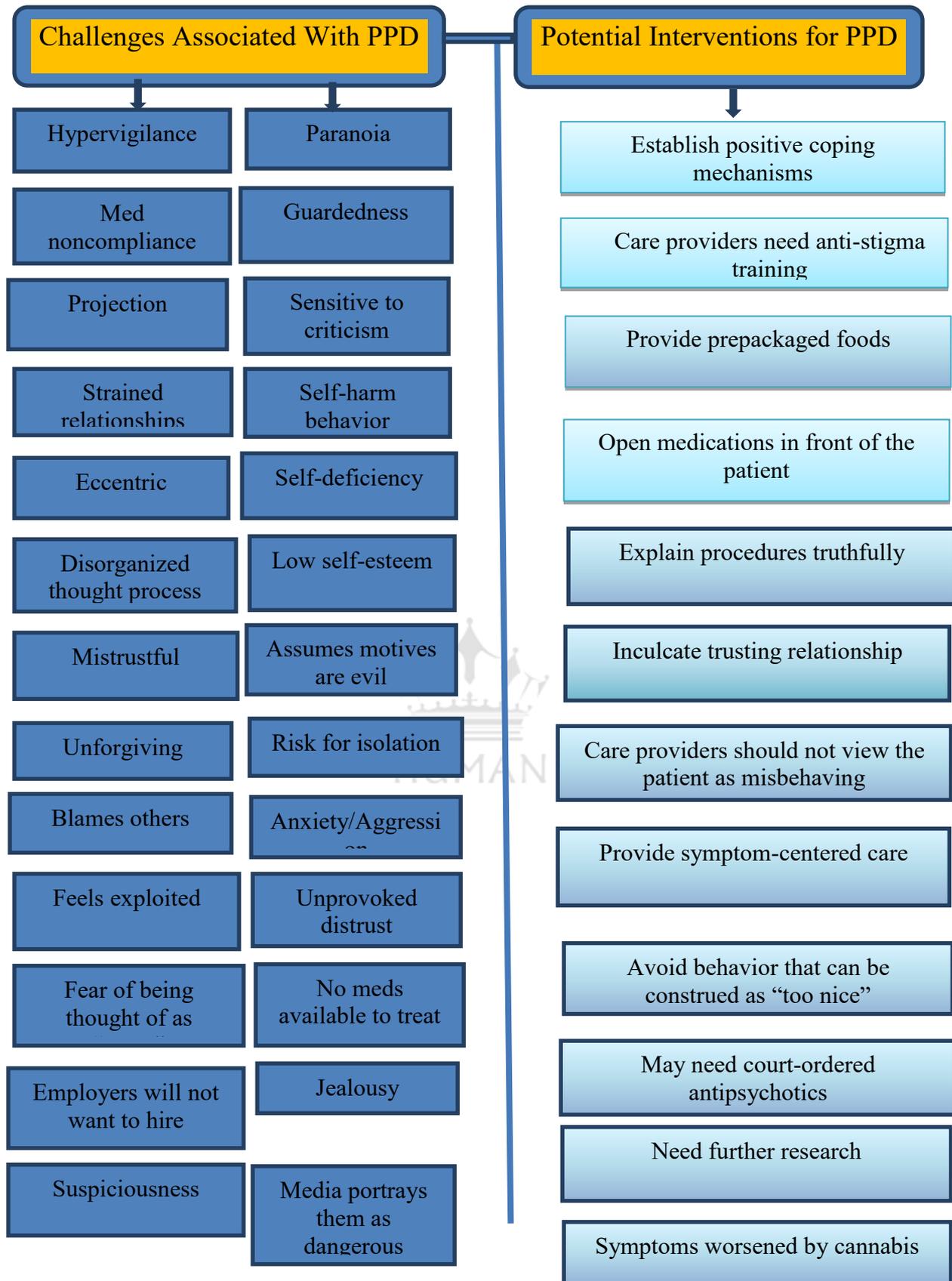


Figure 1. Challenges and intervention for paranoid personality disorders

CONCLUSION

Stigma limits individuals from seeking treatment in fear of being labeled as “crazy” or received lower quality care. Individuals may not receive care until requested by a family or employer. Changing the public’s view and providers view through education can attempt to close the lack of knowledge on personality disorders so individuals can experience less stigma and promptly receive treatment. Careful diagnosis is vital for individuals to receive the treatment necessary and to reduce stigma. Interventions to help individuals during an inpatient stay include opening medications in front of the individual, providing pre-packaged foods, and avoiding behavior that can be construed as “too nice.” Treatment relates to symptom management for anxiety, delusions, and agitation. The antipsychotics can be used to control paranoid ideation. Further research is needed to better understand the challenges of diagnosing PPD, the stigma attached from providers and the public, and effective treatment to promote stigma-free care. With a caring approach, nurses, families, and societies can provide holistic, well-rounded, and symptom centered care.

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