PERSONALITY DISORDERS

Paranoid Personality Disorder

PPD

DSM-5-TR 301.0 | ICD-10-CM F60.0

Pervasive distrust and suspiciousness in which the motives of others are read as malevolent, without the fixed delusions of a psychotic disorder.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~2.3-4.4% US adults	Traits visible in adolescence	Slight male predominance	Chronic; stable across decades

CLINICAL PICTURE

- Exploitation, deception or harm is suspected without adequate basis, and unjustified doubts about the loyalty of friends and colleagues are persistent.
- Confiding is avoided because information is expected to be used against the patient, so history taking is guarded and often incomplete.
- Benign remarks and events are read as demeaning or threatening, and slights are catalogued and recalled verbatim years later.
- Perceived attacks on character that others do not see provoke rapid anger or counterattack, producing conflictual work histories and litigation.
- Recurrent unjustified suspicion of a partner's fidelity is common and may escalate into surveillance, interrogation or controlling behavior.
- Self-referral is rare; patients are usually brought by family, employers or courts after conflict, and they experience assessment itself as adversarial.

DIAGNOSTIC CRITERIA AT A GLANCE

- Four or more of seven suspiciousness features are required, present by early adulthood and evident across a range of contexts.
- Beliefs are overvalued and non-bizarre rather than fixed and encapsulated, which is the essential boundary with delusional disorder.
- The diagnosis is excluded when suspiciousness occurs only during schizophrenia, another psychotic disorder, or a mood disorder with psychotic features.
- If the criteria are met before onset of schizophrenia, the specifier premorbid is added to the personality disorder diagnosis.
- Section III of DSM-5-TR does not retain a paranoid type; suspiciousness appears as a facet within the detachment and antagonism trait domains.

NEUROBIOLOGY & PHYSIOLOGY

- Cluster A heritability is estimated near 21-28% in twin studies, with familial aggregation in relatives of probands with schizophrenia.
- Dopaminergic hyperactivity in mesolimbic salience attribution is the leading model, mirroring the mechanism proposed for persecutory delusions.
- Amygdala hyperreactivity and reduced prefrontal regulation bias threat appraisal, particularly for ambiguous or neutral facial expressions.
- Social cognition deficits include impaired theory of mind and misattribution of hostile intent from neutral faces and ambiguous vocal tone.
- Sensory impairment, especially acquired hearing loss, plus migration and minority stress measurably increase paranoid attribution rates.
- New paranoia arising after midlife demands medical workup for dementia, delirium, stimulant use, thyroid disease and temporal lobe pathology.

PSYCHOLOGICAL MECHANISMS

- An externalizing attributional style assigns negative events to the deliberate acts of specific people rather than to circumstance or self.
- A jumping-to-conclusions reasoning bias produces certainty from minimal evidence, so fewer data are gathered before a conclusion is fixed.
- Hypervigilant scanning for threat guarantees confirming evidence, and disconfirming information is reinterpreted as a more sophisticated deception.
- Projection of the patient's own unacceptable hostility onto others defends fragile self-esteem by relocating blame outside the self.
- Developmental histories often include humiliation, harsh or unpredictable authority, and environments where vigilance was genuinely adaptive.

DIFFERENTIAL & COMORBIDITY

- Delusional disorder, persecutory type, involves fixed delusions held with full conviction; paranoid personality beliefs stay suspicions, however entrenched.
- Schizotypal personality disorder adds cognitive-perceptual oddity, and schizoid personality disorder lacks suspicious attribution altogether.
- Stimulant, cannabis and alcohol-related paranoia plus medical and neurologic causes must be excluded before assigning a lifelong trait diagnosis.
- Comorbid depression, agoraphobia, obsessive-compulsive disorder, substance use disorders and other cluster A conditions are frequent.
- Risk assessment matters: threats and violence toward identified persecutors, litigation and abrupt treatment rupture all occur at elevated rates.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication is approved, and randomized data are absent; pharmacotherapy is reserved for severe suspiciousness or clear comorbidity.
- Low-dose second-generation antipsychotics such as **risperidone 0.5-2 mg/day** or olanzapine 2.5-7.5 mg/day are extrapolated from cluster A trials.
- Metabolic panels, weight, prolactin and extrapyramidal review are required at baseline and periodically, and the lowest effective dose is the goal.
- **SSRIs** treat comorbid depression and anxiety and may soften hostility, but expect scrutiny of every side effect as evidence of harm.
- Explain rationale, alternatives and adverse effects in writing; concealed or hurried prescribing confirms the patient's core expectation of deception.

PSYCHOTHERAPY

- Supportive individual therapy with an utterly predictable frame outperforms interpretive work; reliability itself is the active ingredient.
- Techniques adapted from **CBT for psychosis**, such as generating alternative explanations and testing predictions, reduce distress without direct confrontation.
- Never argue a suspicion down; explore the evidence collaboratively and target the behavioral consequences the patient already dislikes.
- Group therapy is poorly tolerated early because peer remarks are readily misread; defer until individual trust is established.
- Practice radical transparency about documentation, note sharing, appointment length and who else receives information.

ADJUNCT & SUPPORTIVE

- Correct hearing and vision deficits, since sensory misperception feeds misinterpretation and is one of the few reversible contributors.
- Involve family only with explicit written consent; unauthorized collateral contact is experienced as confirmation of conspiracy.
- Occupational and legal consultation can contain litigious escalation and preserve employment where conflict has already begun.
- Perform structured violence risk assessment when a specific target is named, and document the duty-to-protect analysis and actions taken.
- Address substance use and sleep, and pursue full medical workup for any paranoid presentation emerging after age 50.

CLINICAL PEARLS

- Suspicion, not fixed delusion; unshakable and encapsulated points to delusional disorder.
- Transparency about notes and rationale is the intervention, not merely a courtesy.
- New paranoia after 50 calls for a medical workup, not a personality diagnosis.

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NOTE

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