

The puzzling symptom of paranoia

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Summary

Paranoia can present as a symptom, a syndrome or as a personality trait. We present a series of cases, in adults, adolescents and children, where paranoia is the most prominent feature in the clinical presentation, with the objective of discussing difficulties encountered in diagnosis. A total of nine

cases are presented where the initial diagnosis needed subsequent revision. The possible reasons for this are inadequacy of diagnostic classification systems leading to false positive diagnosis, unfamiliarity with certain diagnostic categories, absence of systemic evaluation and cultural factors.

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Introduction

Paranoia was meant to be “out of the mind” according to ancient Greek writing. The current definition however has a broader concept and includes beliefs related to grandiosity, jealousy, persecution, erotic and religious themes. The term paranoia basically implies a morbid distortion of beliefs and attitudes concerning relationships between oneself and other people and situations. Paranoia, like many other psychological phenomena, can present in an affected person in a variety of ways (1,2).

Paranoia as a symptom: This can be an over-valued idea or a delusion. Persecutory type is the most common. Persecutory ideas are common in normal people as an adaptive psychological process, which helps to detect threats to self. Paranoid thinking becomes clinically significant when they become over generalized. Paranoid ideas can be considered as lying in a continuum, which ranges from day to day suspiciousness to clinically significant delusions (3,4). Paranoid ideas occur in 10-15% of the general population, while emotionally distressing paranoia occurs in 5-6%. Prevalence of delusions amounting to a psychotic disorder occur in 1-3% (4,5).

Paranoia as a syndrome: Paranoid symptoms can occur as part of another psychiatric disorder, such as schizophrenia, mood disorder or an organic mental disorder. Such symptoms occur in delusional disorders where there is no other psychopathology (1).

Paranoia as a personality type: Mistrust of other people is a cardinal feature of paranoid personality disorder. They are preoccupied with the idea that others want to harm or deceive them. Hence they are reluctant to confide in others for fear of malicious use of the information given. They perceive innocent incidents as threatening (3). Such paranoid ideas may range from overvalued ideas to full blown delusions (5).

We present a series of cases, in adults, adolescents and children, where paranoia is the most prominent feature in the clinical presentation (Fig 1). The objective is to

highlight the range of clinical presentations one may encounter and discuss difficulties that may arise in arriving at a diagnosis.

Discussion

In all the cases, the symptom of paranoia appears to have directly influenced the original diagnosis that was made. The need to review the patient’s history and revise the diagnosis came as a result of non-response to the treatment already given in cases 1 to 6. In cases 7 and 8, the patients discontinued their medication with no adverse consequences which could not have occurred if the original diagnosis was correct. Case 9 could not be treated immediately as she came seeking help for her son. It is not possible to say that diagnostic errors are more likely in patients presenting with paranoia. Nevertheless, it is worth exploring the possible reasons for diagnostic errors in the above cases and in general.

Current symptom based diagnostic criteria of ICD and DSM can often yield false positive diagnoses as they ignore the context of symptoms such as the psychosocial environment and the experience of the patient concerned (6,7). It is argued that clinical diagnosis of delusions cannot be limited to delusional contents alone, apparent or real (5). Instead, it should take into account how subjective experiences manifest themselves. Further, it also requires an understanding of the inter-subjective process of how beliefs are expressed to and interpreted by the clinician (8). Hence, content of the patient’s belief alone, however impossible or incomprehensible it may sound, may not justify a claim of a delusion (5).

Unfamiliarity with certain diagnostic categories may be another reason for misdiagnosis, where such conditions were not considered (6). The tendency then would be to look for a more familiar diagnosis that would fit in with the patient’s presentation, even if all clinical criteria are not fulfilled (9). This situation may easily occur with patients having Asperger syndrome. Also, their characteristic vulnerabilities, their experiences of life and their unusual expressions of feelings could be very puzzling to a clinician who is not familiar with the condition.

Table- Summary of cases

Presenting problems	Initial diagnosis	Drug treatment	Revised diagnosis	Outcome
<p>1.Male, 12 years Irresistible urge to touch girls. Feeling of being controlled by an unknown force. Hearing a male voice commanding he reads the book 'Lord of the Rings' and asking questions. He attended school but refused to work. He was reading books during lessons and until late at night which disturbed his sleep. He acted out the contents of the book. He had no other interests. He was a loner. He was highly worried about contamination with germs and washed his hands repeatedly. Recent life event-Experience of being bullied</p>	Schizophrenia	Risperidone	Asperger syndrome	Improved without medication with interventions for strengthening social skills.
<p>2.Female, 15 years Believed that neighbours were sending toxic fumes through the windows to kill her. Refused to eat believing that her food was poisoned. Refused to leave her bed as she feared contamination with germs, and repeatedly washed her hands. Was suspicious and quarrelsome and accused family of conspiring against her. Recent life event-Change of residence</p>	Schizophrenia	Risperidone	Severe obsessive compulsive disorder	Venlafaxine Risperidone
<p>3.Female,16 years Believed neighbours/friends were conspiring with a popular radio station to broadcast her personal details; a neighbour was sexually attracted to her and was making advances at her; friends were jealous of her beauty and made a demon follow her; she was a great leader ; she was to become the next president. She was singing and dancing at home inappropriately. Recent life event-Broken relationship</p>	Bipolar affective disorder currently manic with psychotic features	Sodium valproate	Asperger syndrome	Medication is being tailed off
<p>4.Female, 16 years Claimed that a male singer is watching her every action through a hole in the roof above her bedroom; tuition master is sexually abusing her friends and spreading rumors that he is in a relationship with her. She has cut her wrists superficially on several occasions because she was unable to control her anger. Recent life event-Not achieving expected results at examination</p>	Schizophrenia	Risperidone	Borderline personality traits	Lost to follow up
<p>5.Male, 17 years Felt the presence of an unknown being in his room which watched his every move; neighbours and teachers are passing adverse comments on him. Felt sad, had lack of pleasure and interest. He had poor sleep and appetite. Became withdrawn from friends and family members. Preoccupied with demons and drew pictures of them. Preferred to wear black. Recent life event-Broken relationship</p>	Depression with psychotic features	Risperidone	Asperger syndrome	Improved with interventions for strengthening social skills. Fluoxetine was continued.
<p>6.Female, 19 years She was in love with a female school teacher and wished to marry her; wrote love letters to her and fantasized them together making love; desperately desired to be the boyfriend of the teacher; wished she could remove her uterus and breasts; cross dressed as a boy at home and cut her hair short. Recent life event-Teacher praised her for scoring high marks at an assignment.</p>	Delusional disorder- Erotomania	Fluoxetine	Gender identity disorder and OCD	Reluctantly accepted that her desire for surgical intervention will not materialize. On fluoxetine for depression/ OCD.
<p>7.Female 22 years Suspicious, restless and aggressive after learning that her father is heading to Haiti. She heard voices scolding her for putting her father in danger. She shouted in fear that something bad would happen to her father. Had poor sleep and appetite. Recent life event-Father leaving to work overseas</p>	Schizophrenia	Risperidone	Acute stress disorder	Discontinued drug treatment of her own accord within a few days. Felt embarrassed about behaviour.
<p>8.Male 25 years Suspicious about others making sexual advances at him. He suspected people whom he encountered and withdrew from society. He started hating men. He couldn't continue his job as a result. Recent life event-Homosexual encounter</p>	Schizophrenia	Haloperidol	Acute stress disorder	Discontinued drug treatment of his own accord within a few days. Returned to work.
<p>9.Female 32 years Claiming of repeated sexual abuse of her preschool child by relatives. She accused many of her relatives and tried to get information on the abuse by force from the child. Despite her accusations she still sent her child to the alleged abusers' houses and secretly observed them to collect evidence. She believed that the whole neighbourhood was against her. She was suspicious of people around her from her adolescence. Her marriage was disrupted as she suspected her husband of having several extramarital affairs. Recent life event-None identified</p>	Schizophrenia	Olanzapine	Paranoid personality disorder	Cognitive behaviour therapy for paranoid personality disorder

Unique presentations of mental disorders that are influenced by the culture of the patient are well documented and extensively described in psychiatric literature. These influences could be related to ethnicity, religious beliefs, rural or urban living, family values, different 'help-seeking motivations', styles of making sense of the world and dealing with the world (7,10). It is well recognized that diagnostic unreliability is associated with ethnicity and culture. Hence, taking cultural aspects into consideration in assessment is crucial for an accurate interpretation of a patient's symptoms. This is especially relevant in the way people react to psychologically demanding situations (cases 7 and 8). Clinical management of patients across cultures challenges the clinician's familiar tried and tested strategies (6). Familiarizing oneself with manifestations of cultural beliefs in psychologically demanding experiences in the general population would certainly improve diagnostic skills.

The importance of information gathering from a multi-systemic perspective should not be under-estimated, especially in children and adolescents. This would mean that the diagnostic formulation should include temperamental and developmental factors in addition to social, family and biological factors. In most of the cases given here, such additional information allowed a hypothetico-deductive clinical problem solving and in arriving at the revised diagnosis. In the absence of such information, there will not be an opportunity to understand the evolution of the current psychopathology.

Busy clinics and demands on the clinician's time may easily lead to taking short cuts in assessments. Under the circumstances, clinicians too should sharpen their skills to be able to make rapid and accurate assessments most of the time. However, being diagnosed with a psychiatric disorder in its absence will have serious ramifications on the person's social well being and should be avoided at all cost.

Declaration of interest

None

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