The paranoid patient suffers deeply from pervasive feelings of being mistreated and misunderstood, hypervigilance, and an acute sensitivity to real or imagined slights. He is suspicious of other people’s motives and may distrust those he loves most or to whom he is most attached. This patient harbors simmering anger and grudges toward those he feels may have deceived him or taken unfair advantage. His persistent fear and conviction of not being liked, appreciated, or treated properly become a self-fulfilling prophecy as friends, acquaintances, and workmates become alienated by his hostility, suspiciousness, and constant indignation at the insults or psychological injuries to which he believes he has been subjected.

The paranoid patient is constantly on the alert for evidence of deliberate intent that he is being abused, ignored, or subjected to humiliation. He finds subtle clues to confirm this conviction of deliberate mistreatment. Inadvertent or minor social miscues by another person will convince him that he is being purposely ignored or insulted. He need not be delusional, but he misinterprets the significance of events or social interactions to confirm his conviction that he is an object of denigration. The narcissistic aspects of this type of preoccupation are apparent, and, indeed, paranoid thinking is frequently found in the more disturbed narcissistic patient who feels he does not receive the appropriate recognition that his grandiose self-image demands. To the paranoid patient, the world is a malevolent place that is intent on causing him injury. Ultimately, the patient suffers the rejections, aversion, and avoidance that he most fears because of his distortions of reality.

The DSM-IV-TR criteria for paranoid personality disorder capture this crippling cognitive style in its more florid form (Table 12-1). Milder variations, however, occur in patients with many other personality
TABLE 12-1. DSM-IV-TR diagnostic criteria for paranoid personality disorder

<table>
<thead>
<tr>
<th>A.</th>
<th>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:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her</td>
</tr>
<tr>
<td>(2)</td>
<td>is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates</td>
</tr>
<tr>
<td>(3)</td>
<td>is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her</td>
</tr>
<tr>
<td>(4)</td>
<td>reads hidden demeaning or threatening meanings into benign remarks or events</td>
</tr>
<tr>
<td>(5)</td>
<td>persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights</td>
</tr>
<tr>
<td>(6)</td>
<td>perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack</td>
</tr>
<tr>
<td>(7)</td>
<td>has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner</td>
</tr>
</tbody>
</table>

| B. | Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder and is not due to the direct physiological effects of a general medical condition. |

**Note:** If criteria are met prior to the onset of schizophrenia, add “premorbid,” e.g., “paranoid personality disorder (premorbid).”


types or diagnoses. This less disturbed individual will fixate on an insensitive or maladroit comment by a friend or acquaintance, even if it is innocent at heart, and feel intensely affronted. He will react with inner indignation and self-righteous feelings of having been deliberately demeaned by the other person. Simultaneously, he is often highly critical of other people but exempts himself from inner criticism through the mechanism of projection. It is always the other person who is obtuse or thoughtless or who says the hurtful thing. Unconsciously, he gains considerable satisfaction in possessing the moral high ground—the other person is the provocative or insensitive one, never him. These paranoid themes are often present in obsessive, masochistic, or narcissistic patients. More extreme paranoid themes are found in borderline patients with primitive fantasies of being controlled, manipulated, or used in...
some degrading fashion. The psychotic paranoid has developed a delusional belief that he is being deliberately persecuted because a plot has been engineered against him.

Paranoid mechanisms are found in everyone and can be clinically prominent in a wide variety of psychotic, organic, and neurotic disorders. Although the range of psychopathology is great, there are psychodynamic patterns and mechanisms of defense that are common to all of these patients. The greater the degree of paranoia, the more difficult the interview, because the paranoid patient resists the establishment of a therapeutic working relationship. The patient typically comes to complain about something other than his own psychological difficulties or is brought to the clinician by someone else against his will. The paranoid patient is not readily liked and accepted by other people, and the clinician may also respond negatively to him.

PSYCHOPATHOLOGY AND PSYCHODYNAMICS

Paranoid Character Traits

Suspiciousness

The paranoid person is tense, anxious, and basically unsure of himself. He is mistrustful of others and suspicious of their intentions and looks for hidden meanings and motives in their behavior. He has few close relationships, and although he may have contact with many others, he feels himself to be a loner. He may be impressive and even charming at first meeting; however, as people know him better, they like him less.

The paranoid person sees himself as the center of the universe and views events in terms of their bearing on himself. All actions, attitudes, and feelings of others are understood and reacted to in terms of their reference to him. The paranoid patient lacks awareness of his own aggressive impulses but instead fears that he will be attacked or treated unfairly by others, whom he views as unreliable and untrustworthy, thereby justifying his own secretive and seclusive behavior.

Chronic Resentment

This patient's difficulties relating to others realistically cause him to feel awkward and ill at ease in social situations. Every slight is interpreted as a personal rejection. He collects injustices, and his vivid memories of these experiences are never forgotten. He is argumentative and quarrelsome, manifesting impatience and angry emotional outbursts in situations in which others contain themselves. Inappropriate reactions of
anger occur in heavy automobile traffic, while waiting in line, or in response to being pushed and bumped in a crowd. The paranoid person, like the narcissistic patient, expresses resentment over his feeling of being unloved and unappreciated by the world. The paranoid person, however, goes further, attributing malevolent motives to those who do not appreciate him. He frequently fixates these feelings on a specific individual or group whom he feels does not like him. The narcissistic patient says, “That is just the way people are,” with an attitude of arrogant contempt. The paranoid person, however, says, “He has been out to get me,” with angry resentment.

**Justice and Rules**

Justice and fairness are major preoccupations for the paranoid person. In his concern about safeguarding his rights, he may obtain instruction in the art of self-defense, such as boxing or karate, and he may possess firearms, knives, or other weapons. A compulsive concern with honesty and dedication is a thin disguise for concealed rage. The mistrust of the paranoid patient underlies his concern with the literal interpretation and rigid enforcement of rules and regulations. At the same time, he is unable to appreciate the spirit of rules, and he tends to interpret them mechanically without considering people’s feelings.

He also uses the rules to control the direct expression of his own aggression. For example, one patient described how he had spent many hours scrutinizing the laws in anticipation of preparing his income tax return. He reported triumphantly that he could deduct the cost of the postage for mailing the forms. He was determined to get everything that was due him without breaking the law. At times the patient’s own minor violations lead to exaggerated fears of detection, but at the same time he searches out loopholes that permit him to express some of his aggression while denying the significance of his behavior.

A similar rigidity concerning rules is found in obsessive patients, but the obsessive person is more likely to bend the regulations for his friends. The obsessive patient is concerned with the authority and status issues represented by rules—who has the power to make them and who has the power to violate them. Rules stimulate his obedience-defiance conflict. Because paranoid and obsessive traits frequently coexist, it is common to find both mechanisms in the same patient.

**Grandiosity**

The paranoid patient creates an impression of capability and independence, neither needing nor accepting assistance from others. He is opin-
ionated and insists that he is right. His tactlessness and attitudes of superiority, arrogance, and grandiosity antagonize other people. These traits also make him an easy target for insincere flattery and praise, and such recognition quickly reestablishes his childhood feelings of grandiose omnipotence. The paranoid patient is resentful of others when appreciation is not immediately forthcoming. That person is then viewed as stupid, contemptible, and incompetent. This patient frequently reports receiving recognition before he has earned it through adequate achievement. He describes such experiences with a feeling of having been rescued and may relate that his performance actually improved after this unearned and unconditional acceptance.

Because the paranoid person is confident that his goals and ambitions are for the betterment of mankind, he sincerely believes that his ends justify his means. He frequently develops missionary zeal and expects to convert the world to a more perfect place, but he loses sight of how he treats other human beings while accomplishing his purpose. The paranoid personality is attracted to extremist groups, both political and religious; he is more concerned with the rigid application of a system of ideas than the principles contained in them. He is a revolutionary, but he is always disenchanted, even if his revolution succeeds.

**Shame**

It is common for the paranoid patient to report that he was treated sadistically in early childhood, with repeated experiences of shame and humiliation. Many of the patient’s problems stem from his constant sense of humiliation over his failure to control and regulate himself and his environment properly. When he becomes aware of some deficiency, he reacts as though he had soiled himself publicly and everyone were ridiculing him.

He finds it difficult to apologize for a transgression and equally difficult to accept the apologies of others. The paranoid patient confuses forgiveness with the admission of having erred. One patient who had experienced a realistic slight from her therapist delineated this problem by saying, “If I forgive you, that means that I was wrong.”

**Envy and Jealousy**

Envy is a prominent paranoid character trait. The paranoid person is more concerned with the privileges and gratification that others receive than with his own deprived and emotionally barren existence. His preoccupation is with fairness as defined by him. He does not have the narcissistic person’s eternal quest for power and status. He is unable to
trust, which precludes his ability to love others or to allow them to love him. He longs to trust others, but his preoccupation with betrayal blocks any love relationship. If he begins to trust another person, he imagines signs of betrayal and accuses his partner of cheating on him.

The paranoid person is extremely jealous because of his inability to love and his strong narcissistic needs. He has an intense longing to be loved and an equally intense fear of betrayal. This is discussed in greater detail later, under “Psychodynamic Theories of Paranoia.”

**Depression and Masochism**

Paranoid patients can have an underlying depressive trend. Clinically, when a paranoid defense is no longer effective, depressive feelings may overwhelm the patient. Suicide is not uncommon in acutely paranoid patients. The paranoid person believes that he is not loved, has not been loved, and never will be loved. Feeling persecuted, he considers himself a loser, and his life is spent in suffering (according to his view) at the hands of others. Even the patient with grandiose delusions loses, because he is inevitably confronted by reality when these delusions do not come true. Many of these patients are now recognized as having a bipolar type II illness. The paranoid person is an eternal pessimist, always expecting the worst. He interprets his misfortunes, disappointments, and frustrations not as chance but as the result of personal malevolence from someone else. He is unable to ask for love directly and can only obtain it through pain, self-sacrifice, and humiliation. The intensity of his demands is exorbitant and ensures disappointment. Unable to accept real gratification of his need to be loved, he substitutes fantasies of revenge. Too much of his enjoyment comes from observing the misfortunes and failures of others rather than from his own success.

Success has its own difficulty for the paranoid person. He expects that others will react to his success with intense jealousy and that he will soon become the victim of their retaliatory rage. Therefore, his acceptance of success leads to fear and anticipation of punishment. He cannot enjoy being a winner any more than he can enjoy the role of loser. He disbelieves or depreciates his success to avoid feeling that he has outdone his competitors.

The grandiose paranoid patient is better able to accept success, particularly when it is associated with some idealistic cause. His success is always for the enhancement of “the cause” rather than for personal gains. In his private life, the masochistic aspect becomes more apparent, with asceticism a prominent feature.

The obsessive-phobic character also has fears of success, but the psy-
chodynamic conflict is more clearly related to the patient’s competitive relationship with the parent of the same sex for the love of the parent of the opposite sex. The conflict in the paranoid patient is at an earlier developmental level.

**Differential Diagnosis**

As with the other serious personality disorders, the major differential diagnoses include borderline personality disorder, obsessive-compulsive personality disorder, narcissistic personality disorder, masochistic personality disorder, antisocial personality disorder, and bipolar spectrum disorders. In certain ways both the paranoid patient and masochistic patient are extensions of narcissistic personality disorder in their unconscious belief that they are the center of the universe, albeit a distorted universe. The thematic element that distinguishes the paranoid patient is that of misplaced trust, fear of betrayal, and explosive anger. The paranoid patient longs for a loving relationship, but his mistrust or trusting the wrong person precludes love and becomes a self-fulfilling prophecy of rejection. The future narcissistic patient, as a child, is made to feel special, whereas the future paranoid patient is mistreated during childhood in many subtle or overt ways and frequently goes on to mistreat others. This element of abusing others can overlap with the antisocial personality. The future paranoid patient as a child is not happy, is often angry, is frequently a loner, and may be either a victim or a bully. There is much more overt aggression in both the history and the presentation of the paranoid patient than one finds with the narcissistic patient. The paranoid patient is often sensitive to only his own dynamics, which are suffused with suspiciousness and hostility; thus he is remarkably insensitive to much that goes on around him, which is in contrast to the narcissistic patient. It is as if he is only resonating to one tune, that of potential mistreatment and betrayal. Paranoid rage has been described as a “red rage,” one that is seething and has a potential for violent explosion. This stands in contrast to the “white rage” of the offended obsessive patient, whose self-control inhibits striking out but who is ragefully planning “cool” vengeances against those who have crossed him. Potential or real explosive aggression is the leitmotif of the paranoid patient and can be disturbing to the interviewer.

The grandiosity of the paranoid patient differs from that of the manic or narcissistic patient. The grandiosity of the paranoid patient revolves around his belief that he is the center of the universe and that malevolent forces are arrayed against him because of his specialness. He is on the alert for attack and betrayal. The manic patient is far more
expansive and elated in contrast to the foreboding of the paranoid patient. The manic patient may see himself as a "genius" who should be recognized as such, although he can become paranoid if rebuked, crossed, or not acknowledged. The narcissistic patient merely feels that he is far more important than anyone else and can generously dispense his glory to those around him, all of whom should rightfully acknowledge his grandness. Again the differentiating factor lies in the quotient of intense aggression that imbues the paranoid patient in contrast to the narcissistic patient.

Psychodynamic Theories of Paranoia

Freud’s conception of the nature of paranoia was based on his study of the memoir of the distinguished German jurist Schreber, who developed a late-onset psychosis replete with complex persecutory and grandiose delusions. Freud felt that the basic motivation at the core of the disturbance related to unconscious homosexuality. In the Schreber case, Freud postulated that unconscious homosexual tendencies were warded off by denial, reaction formation, and projection. The feeling that “I love him” was denied and through reaction formation became “I do not love him; I hate him,” and then through projection was transformed into “It is not I who hate him; it is he who hates me.” The patient once again experienced the feeling of hate, but now he rationalized, “I hate him because he hates me.” In Freud’s view, this series of defensive maneuvers was involved in delusions of persecution. In the formation of grandiose delusions, the denial of homosexual impulses occurred through the process: “I do not love him; I do not love anyone—I love only myself.”

Freud thought that unconscious homosexuality was also the foundation for delusions of jealousy. The patient’s preoccupation with jealous thoughts was the residue of his ego’s attempt to ward off threatening impulses. Through the mechanism of projection, unconscious wishes of the patient were attributed to others. The patient asserted, “I do not love him; she loves him.” The “other man” whom the paranoid patient suspects his wife of loving was actually a man to whom the patient felt attracted. This is often borne out clinically when the wife of the patient confides to the clinician, “I actually have been interested in other men, but it has never been anyone whom he suspects.” The paranoid man often wishes to possess a beautiful female in order to attract the attention of other males. His self-esteem is elevated by other men’s attraction to his “trophy woman,” just as though it were his penis that was being admired. This phenomenon is also seen in narcissistic men.
Heterosexual impulses to be unfaithful also may be projected onto the spouse, leading to pathological jealousy.

Freud felt that narcissistic regression had contributed to unconscious homosexual wishes in that the paranoid patient had withdrawn his interest from others and concentrated it upon himself. His ambivalent feelings of self-love and self-hate were expressed when he became enamored of another person who unconsciously represented himself. He inevitably turned against these love objects, attacking them for the same qualities that he hated in himself. This process was the same whether the love object was a real person or a delusional figure. The intense interest in persons of the same sex aroused unconscious erotic feelings and fears of homosexuality. The patient's narcissistic wish to meet his own body and parts thereof in the external world is reflected by certain clinical material. Patients may reveal that some parts of the body of persons in their delusional world remind them of parts of themselves. Often the buttocks are involved in such thoughts. The frequency of anal preoccupation in paranoid patients often reflects their obsessive conflicts and passive submissive longing for intimacy.

Although conflicts referring to homosexuality are clinically common in paranoid patients, Freud's view of the etiological centrality of unconscious homosexuality is no longer accepted. Some writers claim that a significant number of paranoid patients have no concern with this problem. It is difficult to test Freud's theory, since paranoid patients are typically secretive and often withhold material from the interviewer that pertains to homosexual conflicts. For example, one patient initially denied homosexual concerns in association with his delusions of being poisoned. Finally he admitted that the "poison" was "hormones," and then he acknowledged that it was "sex hormones." Ultimately he revealed his belief that he was receiving female sex hormones. Some paranoid patients are treated for years before disclosing such material. However, contemporary psychoanalysts have emphasized the paranoid patient's preoccupation with being inferior, demeaned, and viewed with contempt, with homosexuality a concrete symbol of that state in our culture, particularly for heterosexual men. For some female paranoid patients, accusations of being promiscuous or a prostitute play the same role.

Mechanisms of Defense

Primitive denial, reaction formation, and projection are the basic defenses in paranoid persons. They are most prominent in the overtly delusional patient. These defenses are first encountered early in the
interview, when the patient indicates that he has no problem and does not need to be a patient or does not require hospitalization. The paranoid person utilizes reaction formation to defend himself from awareness of his aggression, his needs for dependency, and his warm or affectionate feelings. In this way he is protected from betrayal and rejection by others. One patient reported, "If I say I don't care about you, then you can't deflate me."

The paranoid person utilizes denial to avoid awareness of painful aspects of reality. Fantasy serves to bolster this denial. This mechanism underlies delusions of grandeur as well as other feelings of omnipotence. Although the paranoid patient sometimes reports his own experiences in great detail, he often completely disclaims any emotional response to a given event. Although the paranoid patient is hypersensitive to those traits in others that he denies in himself, he is a poor observer of others except in the narrow area of his own hypervigilance.

The paranoid person is consumed with anger and hostility. Unable to face or accept responsibility for his rage, he projects his resentment and anger onto others. He then relies on rules to protect himself from fantasied acts of attack or discrimination, which represent his own projected impulses. The patient denies the aggressive significance of his own behavior and is insensitive to its impact on others. If the patient with persecutory delusions is able to recognize some of his anger, he views it as an appropriate response to the persecution he receives in his delusional world. The patient with grandiose delusions is more apt to feel that others resent him because he is so great. He, of course, considers himself to be above feelings of anger. The mechanism of projection enables the patient to imagine that he is loved by someone to whom he is attracted, or he may use projection as a defense against unconscious impulses that he finds unacceptable in himself. The latter case is exemplified by the 75-year-old unmarried woman who imagines that men are breaking into her apartment with some sexual designs. Her delusion reveals not only her frustrated sexual wishes but also her projected hostility toward men.

Another aspect of projection is exemplified by the patient’s own superego criticisms that are projected when denial and reaction formation fail to handle his guilt feelings. This is illustrated by the patient who believes that his persecutors are accusing him of dishonesty. Many delusions are critical or frightening, thereby implying a projection of superego processes. Furthermore, paranoid mechanisms are often triggered by intense feelings of guilt.

The defense of externalization as used by the paranoid person is similar to projection in its genesis. The patient accepts no responsibility
in interpersonal situations because of extreme inner feelings of shame and worthlessness. Everything that goes wrong must be seen as someone else’s fault. Obviously, the paranoid person alienates himself from others by constantly blaming them for his own misdeeds or failures.

Paranoid symptoms involve regression to earlier levels of functioning. This regression affects the entire personality, including ego and superego functions. Superego regression is revealed by a return to the early stages of conscience formation, when the patient was fearful of being watched by his parents.

The fundamental feeling that is projected by every paranoid patient is his self-image of inadequacy and worthlessness. In the male heterosexual patient, this may be symbolized by the self-accusation of homosexuality. The projected accusations in the delusions of female paranoid patients often involve prostitution or fears of heterosexual attack and exploitation rather than homosexuality. This difference can be traced to the girl’s early relationship with her parents. When she turns to her father for the maternal love that she is unable to receive from her mother, she begins to develop heterosexual desires rather than homosexual wishes. These are later repudiated and projected in fears of rape or hallucinated accusations of prostitution. The common theme in both male and female patients is that of being a degraded and worthless sexual object.

The paranoid man’s childhood power struggle with figures of authority may also contribute to his fear of homosexuality. The homosexual thoughts and feelings reflect the incomplete resolution of this power conflict, with the resulting development of inappropriate attitudes of submission and regression to dependent modes of adaptation, which are symbolically represented by homosexuality. Phrases such as “getting screwed” or “getting the shaft” illustrate the symbolic homosexual significance that our culture attributes to a situation in which one is forced to submit to unfair treatment. Because of intense ambivalence over such wishes, paranoid persons may resist normal cooperation on one occasion only to submit to some totally unreasonable demand on another.

A further understanding of the psychodynamics of the paranoid patient has been developed by Auchincloss and Weiss. They noted that anyone may become paranoid when his or her security or connectedness with important others is severely threatened. This can happen, for instance, to a soldier in a frightening combat situation and occurred frequently during the murderous trench warfare of the First World War. They suggested that the paranoid patient, in contrast to other people, regularly suffers from a failure of object constancy—that is, the psycho-
logical capacity to maintain a mental image of another person even in his or her absence—and thus his connectedness to others is always threatened, even when no obvious external threat exists. The paranoid person cannot maintain a constant loving attachment to the internal mental representation of another person. In the face of intense frustration or rage toward that person, often precipitated by separation, he resorts to thinking about him or her in magical, concrete ways. For instance, the paranoid patient is convinced he “knows” what the therapist is thinking and what the therapist is trying to do to control the patient’s thoughts or actions. Through this pathological mechanism the paranoid patient maintains his connectedness, often feeling he is constantly being thought about by the therapist. Inwardly, when faced with this paranoid self-referentiality, the therapist may be tempted to say, “You’re not that important; not everybody constantly is thinking about you.”

The paranoid person can only feel connected to another person by thinking about that person all the time, even if in a hostile way, thus maintaining a sense of connectedness. An intolerance to indifference—to not being thought about constantly—is one factor at the core of the paranoid patient’s psychopathology, reflecting problems with object constancy. This inability to maintain a constant mental representation of another person, even in the face of separation or empathic failures, precipitates defensive fantasies in the paranoid person of being secretly controlled, manipulated, or otherwise used unfairly.

Paranoid Syndromes

Hypochondriasis

Hypochondriasis is not a disease entity but a symptom complex found in paranoid illnesses, schizophrenia, depression, anxiety disorders, organic psychoses, and some personality disorders. Paranoid patients may complain of insomnia, irritability, weakness, or fatigue as well as strange sensations in their eyes, ears, nose, mouth, skin, genitals, and ano-rectal area. These areas represent the chief routes through which the patient’s body can be penetrated or invaded by others.

Paranoid hypochondriasis is often accompanied by withdrawal from emotional involvement with other people. The ego develops as the infant differentiates his own body from the external world. Direct observation of infants reveals that the initial discovery of one’s own body is a pleasurable process. However, in hypochondriasis the rediscovery of the body is intensely painful. As the patient’s interest fixates on his physical self, he experiences fears of damage and death. This may
symbolize castration anxiety, or it may directly reflect an awareness of impending psychological disorganization. The threat of psychosis may be defended against as the patient symbolically attempts to localize or wall off the disintegrative process in one part of his body.

In the patient's view, his social withdrawal is caused by his physical suffering. He is relieved to find an organic basis for his suffering that further fixes his attention. If no organic basis for his complaint is found, he is likely to seek medical help elsewhere. In more severe cases, the interviewer will respond to the hypochondriacal symptoms as he would to a delusion; this is discussed later. Other variants of hypochondriacal reactions may be found in depressed, anxious, and narcissistic patients.

The negative or painful feelings associated with hypochondriasis reflect the patient's hostile, antagonistic feelings that have been withdrawn from others and turned against himself. Although these patients have always experienced some social isolation, the further withdrawal of interest from others is now accelerated. The patient may report that since the onset of his physical preoccupation, he has quit his job and stopped seeing his few friends, and he now devotes all of his time to matters related to his illness.

The specific symptom choice may represent the patient's ambivalent identification with a parent or parent surrogate. To illustrate, a patient who was preoccupied with his bowels revealed that his father had died of a carcinoma of the rectum. Exploration of the symptom revealed both the positive aspect of the identification and the hostile competitive feelings toward the father that were now turned inward. The interviewer can learn much about the patient's psychodynamics through a careful study of his hypochondriacal symptoms.

Paranoid Psychoses

Paranoid themes are common in psychoses, particularly schizophrenia but also delusional disorders, affective disorders (both manic and depressed), and organic brain syndromes. Although the etiology of these conditions is different, the problems in interviewing are essentially the same.

The paranoid schizophrenic psychosis usually has a gradual onset. The patient withdraws from emotional contact with the people in his life. A common sequence is hypochondriasis, persecutory delusions, and then grandiose delusions. Although there is some controversy over the nature of delusions, one psychodynamic view is that they serve a reparative function. The patient who has been preoccupied with him-
self shifts his interest from his own body and attempts to reestablish contact with those persons from whom he has withdrawn. He is unable to accomplish this, and the world appears to be chaotic and disturbing. He cannot make sense out of the behavior of others, and he desperately searches for the clue that will explain their actions. The delusional concepts that emerge represent the patient’s effort to organize himself and to reestablish contact with the real world. Cameron coined the term *pseudo-community* to describe the group of real and imagined persons who are united (in the patient’s mind) for the purpose of carrying out some actions against him. As the patient becomes a more active participant in his pseudo-community, he behaves in a more grossly psychotic manner. The fantasy world of the delusion is designed to protect the ego from the pain of reality.

A delusion is a fixed belief that is usually false but, more fundamentally, is impervious to evidence, reason, or persuasion by one’s normal reference group. It is usually based on denial, reaction formation, and projection. It reflects a degree of confusion between the self and the outer world. The essence of delusional thinking is not just the lack of correspondence with external reality but the fixity of the patient’s conviction and his inability to alter his ideas in response to evidence of their irrationality. The capacity for delusion formation rather than the specific type of delusion is the patient’s basic pathology. In paranoid characters the same rigidity of persecutory thinking exists and is not responsive to evidence of irrationality, but this patient is not necessarily delusional.

Closely related to delusional thought is the paranoid person’s fascination with extrasensory perception, mental telepathy, and similar occult phenomena. The paranoid patient’s affinity for these strange modes of communication is consistent with his regression to the magical thinking of childhood. The process is defensive in that it validates the patient’s reparative distortions and convinces him that he is right. It also reflects his basic social ataxia and lack of understanding of interpersonal relations. Because he has withdrawn his emotional investment from others and has fixated on himself, his ability to relate to others is impaired. These unusual means of communicating represent his attempt to restore contact with other humans by those primitive techniques that are still available.

The content of the patient’s delusions is determined by his psychodynamic conflicts, by the general cultural values of the society in which he lives, and by the specific characteristics of the family in which he was raised. The clinician can learn the patient’s psychodynamic conflicts most quickly through a careful study of the patient’s delusions. The
defense mechanisms and psychodynamics of delusions have already been discussed. Different types of delusions are delineated in the following sections.

**Delusions of persecution.** Delusions of persecution are the most common delusions found in paranoid patients. The persecutor represents not only the ambivalently loved object but also a projection of aspects of the patient. There usually is some realistic basis for paranoid projections, although it has been vastly exaggerated by the patient. The patient’s tendency to distort reality is furthered by the patient’s particular sensitivity to the unconscious motives and feelings of others. However, he cannot differentiate their unconscious feelings from his own.

Persecutory delusions usually reflect the social issues of concern to the culture in which the patient resides. Political conspiracies, modern science (e.g., computers, cyberspace, genetic engineering), racism, sexual attitudes, and organized crime are the most popular themes in paranoid American patients today, whereas the Japanese and Germans were more prominent in delusions 60 years ago, and until the collapse of the Soviet Union, communist conspiracies were common.

**Delusions of grandeur.** Feelings of great artistic or inventive talent or of being a messiah provide the most common content of delusions of grandeur. They are, however, far more common in the delusions of the manic patient. From the viewpoint of differential diagnosis, such delusions in the manic patient are accompanied by an elevation of mood state, a euphoric grandiosity that is not present in the paranoid patient. The patient may or may not be aware that his fantasized abilities are unappreciated by the rest of the world. Sometimes grandiose delusions have been preceded by delusions of persecution. The patient may seek to avoid the painful feeling of persecution by telling himself that he must be a very important person to merit such treatment. Compensatory grandiosity assists projection in defending the ego from the full significance of the entry of unacceptable impulses into consciousness as well as warding off feelings of inadequacy.

**Erotomania or delusions of being loved.** Erotomaniac delusions most often occur in female patients. The basically grandiose delusional system becomes centered and fixated on one individual, usually an older male. The patient believes that this man has fallen in love with her and is communicating that love through various secret signs and signals.

Milder nonpsychotic forms of this problem are seen in the female student and the older male teacher—often an English or a French teacher.
The student does extra academic work, stays after school to assist the teacher, and soon becomes his pet. The teacher is romanticized and endowed with magical omnipotence and omniscience. His attention and interest are misinterpreted by her as she attempts to compensate for feeling unattractive to boys her own age. This state blends imperceptibly into psychosis in the case of the girl who feels that her teacher’s selections of poetry are chosen particularly with reference to her and that they contain covert messages of his devotion.

The erotomanic patient may develop intense rage toward the object of her delusion. Such reactions can occur independently of any real rejection on the part of this person, or they may occur as reactions to a trivial slight. Male patients may develop erotomanic delusions involving a female pop singer or actress. If he pursues her, he is usually jailed for harassment. He can become dangerous.

**Somatic delusions.** Patients with somatic delusions have a more severe form of pathology than those previously discussed as hypochondriacal. Their preoccupations have become focused on a particular part of their body and have reached delusional proportions. The parts of the body and the psychic mechanisms most commonly involved are the same as those discussed in the earlier section on “Hypochondriasis.” The specific choice of symptoms always has psychodynamic significance.

**Delusions of jealousy.** Although all paranoid patients are extremely jealous, this can only be considered delusional when an organized system has been constructed by the patient. The patient’s partner is the most frequent target for this delusional jealousy.

**Drug-Induced Paranoid States**

Cocaine, lysergic acid, marijuana, phencyclidine, and amphetamines readily induce acute paranoid states that are reversible when the drug use is stopped. The use of anabolic steroids by professional athletes, bodybuilders, and fitness enthusiasts can also lead to severe rage-filled paranoid conditions in some individuals. One articulate athlete described his condition thus:

> It was like I was always in a slow burn, prepared to jump out of my car at any time and confront anyone on the road who bothered me by driving too close, too slow, or weaving in front of me. I would explode at other people at the drop of a hat—in restaurants if the service was not fast enough, at my elevator man if the car was held at another floor, at
my wife if she was 30 seconds late. My flashpoint was so low I could be set off by anything. Now that I’ve stopped using the drugs, it’s hard to believe what I became when I was on them. I was some sort of monster ready to erupt at any minute.

**Developmental Psychodynamics**

Although genetic, constitutional, and cultural factors are also important in the development of paranoid disturbances, this section focuses on the role of psychological conflict. The focus is on clinical observations, without regard to their etiological significance. Nevertheless, we hope that these observations will provide the clinician with guidelines for investigation during interviews with such patients.

Melanie Klein postulated that everyone goes through a *paranoid-schizoid position* during early development. The infant, in her view, is terrified of the “bad”—that is, frustrating—mother and projects his own aggression aroused by this frustration back at the mother. This mechanism of projection is combined with introjection of the “good” or satisfying mother. The image of the mother is thus split, and this process of projection and introjection continues until, with further development, the images of “good” and “bad” mother are integrated into a single mental representation of the parent that combines both characteristics. These mechanisms are believed by object relations theorists to be central to the splitting found in borderline patients, in whom a person important to them may go from being idealized to denigrated in bewildering fashion, an experience often encountered by their therapist. The mechanism of projecting “badness” onto external figures, a residue of the paranoid-schizoid position, is felt by object relations theorists to be at the heart of the psychopathology of the paranoid patient. In the Kleinian view, the infant fears that malevolent objects from the outside will invade and destroy him. Whether or not this theory is correct, such unconscious fantasies can be found in the adult paranoid patient.

From the viewpoint of the ego-psychological conflict model of development, the paranoid person experiences difficulty in establishing a warm and trusting relationship with his mother. His feeling of rejection leads to difficulty in developing a sense of identity in this early symbiotic relationship. Feelings of worthlessness alternate with contradictory and compensatory feelings of grandiose omnipotence. Perceiving his mother as rejecting, the future paranoid patient turns to his father as a substitute. In the male, this leads to fears of passive homosexual wishes. These fears are accentuated by the parents’ anxiety over their young son’s turning primarily to his father for nurturing love and closeness.
the female, fears of sexual involvement arise as she turns to the father for the affection that she is unable to obtain from her mother, causing a regression to earlier homosexual attachments. These fears are later interpreted in oedipal terms, with the result that the girl's fear of attack from her mother is intensified. She develops a secondary fear of attack by men as her incestuous desires are warded off through projection.

This patient learns early in life that his parents are motivated by feelings other than love and closeness. Their behavior is inconsistent with their words; consequently, the future patient is forced to rely on his own observations and on what he is able to read between the lines. Sadistic parental attacks are common from either or both parents. The father may be rigid, distant, and sadistic; weak and ineffective; or possibly totally absent. The obsessive patient typically receives parental love and approval as long as he is obedient. The paranoid patient, however, submits to authority only to escape attack and receives little and inconsistent nurturing love and warmth as a reward. The patient equates his parents' attacks as a form of rape, and this is later apparent in his fears of penetration. This fear is also a defense against his passive, submissive feelings toward his father, which stem from a longing for his love, as well as a defense against the rage felt toward him. Intense feelings of anger and hate develop and are dealt with by denial, reaction formation, and projection. Identification with the aggressor becomes a prominent mechanism of defense in his actual life behavior as well as in the structure of his delusions.

The mother in such families is often overly controlling and frequently seductive, exposing the child to sexual stimulation either directly herself or indirectly through siblings, with total denial of the significance of such stimulation. If the mother is the sadistic parental figure, she is likely to have prominent paranoid features. Her grandiosity leads her to feel that she is always right and the child is always wrong. Under these circumstances, the child develops little sense of worth or individuality but instead denies his ambivalence and attempts to ally himself with his all-knowing, all-powerful mother. The more the child is rebuffed in his attempt to identify with the aggressor, the more likely it is that persecutory attitudes will later develop. Because his self-esteem is achieved through identification with an omnipotent, aggressive parent, he feels that he should automatically and immediately be recognized without demonstrating his worth. The patient's mother often attempts to dominate and control her offspring through the threat of frustration and withdrawal. Therefore, intimacy and closeness become dangerous. The child's occasional intimate experiences with the mother typically lead to humiliation or rejection. The resultant fear of
intimacy is prominent in the paranoid patient, and closeness is avoided at all cost. As a result, the future paranoid patient also learns to deny his warm, tender, and sexual feelings. The child expects that all close relationships require the abandonment of independence and the adoption of a passive, submissive attitude, reawakening his rage when others do not submit to him and thereby demonstrate their love. His defense is the identification with the aggressor.

Just as his parents have inadequate social skills, the paranoid person also is unable to acquire the coping mechanisms necessary for acceptance by others in his environment. His parents' lack of consideration for his rights as a human being leads him to lack appreciation either of his own rights or of the rights of others. He compensates for his isolation and loneliness with an increase in his grandiosity. This attitude in turn leads to renewed rejections from others and further entrenches his feelings of persecution.

Although obsessive, phobic, depressive, histrionic, and narcissistic symptoms are common in childhood and preadolescence, paranoid symptoms are unusual before middle adolescence. Paranoid psychotic patients tend to show less severe regression or deterioration than other schizophrenic patients, an observation that seems in part to be explained by the later age of development. Although this is not well understood, it may be related to the fact that full-fledged paranoid syndromes require experience with a rejecting environment other than that of the patient's family. Another factor is the highly developed capacity for logical thinking associated with the production of delusions.

Paranoid behavior is, in part, learned behavior and is based on the attitudes of the parents. This patient may develop a close peer relationship during the preadolescent years; however, his parents warn him not to trust his friends and not to reveal confidences about himself or his family. Puberty, with its intensification of sexual impulses, creates problems for the paranoid person. He is unable to make the transition from preadolescence to adolescence, with the consequent shift of emotional interest from members of the same sex to members of the opposite sex. His deflated sense of self-esteem and fear of sexual impulses cause him to remain distant and aloof from members of the opposite sex. The young boy is fearful of women and relates better to other males. His fears include both fear of domination and fear of rejection. His avoidance of women requires intensification of his defenses against homosexuality. Similar problems occur with a girl who fears either sadistic attack or rejection and disinterest such as she experienced from her father.
Precipitating Stress

There are two classes of stress that precipitate paranoid reactions. The first consists of situations similar to those that precipitate depressive episodes. These include the real, fantasied, or anticipated loss of love objects. Closely related are experiences of adaptive failure with consequent loss of self-esteem, such as occurs after losing a job or failing in school, with the associated expectation that significant other persons will reject the patient. Paradoxically, success as well as failure may precipitate paranoid episodes as a result of the patient’s fantasy of retaliation from envious competitors. The third major category of situations that precipitate paranoid reactions includes those in which the patient has been forced to submit passively to real or fantasied assault or humiliation. These range from injury incurred through an accident or an assault to situations in which the patient is forced into a passive, submissive role in his occupation. In the latter case, the patient may project his wishes to submit passively, with the resulting fantasy of having been overpowered or assaulted. Competitive experiences may lead a paranoid person to feel that he must submit or they may stimulate intense feelings of aggression. Situations in which there is an intensified stimulation of homosexual feelings, such as confinement in a closed space with other males on a navy or merchant ship, can lead to acute paranoid reactions. In all of these instances, the paranoid response may be initiated by the intense guilt or feeling of shame that overwhelms the patient. He may experience this guilt over his failures, his successes, or his passive submissive wishes.

MANAGEMENT OF THE INTERVIEW

The paranoid patient’s anger is a prominent feature in the initial interview. This may emerge as negativistic withdrawal, an angry filibuster, assaultiveness, or irrational demands. Once the interview is under way, the patient’s profound mistrust presents additional problems. His hypersensitivity and fear of rejection make interpretation and confrontation extremely difficult. However, when psychotherapy progresses successfully and a trusting therapeutic relationship slowly develops, the therapist becomes the most important person in the patient’s life.

The Opening Phase

Anger and Silence

The patient who has been brought for psychiatric care against his will frequently expresses his angry feelings by refusing to talk. However,
unlike the catatonic or severely depressed patient, the angry psychotic paranoid person does not remain aloof from his human environment. His withdrawal is not only a defense against anger but also a means of expressing such feelings. The patient welcomes any opportunity to give vent to his anger and hate. The interviewer can establish initial rapport with the patient by recognizing this and commenting, “You seem to have been brought here against your will” or “I gather you felt coerced into coming here.” The clinician has not agreed with the patient’s interpretation but has shown an interest in learning more about it. Usually such remarks will start the patient on a long, angry diatribe that allows the interviewer to engage the patient. If the patient is already hospitalized and this approach does not induce him to talk, it is helpful to say, “I have to assume that you were admitted to the hospital for some reason, and at least until I have evidence that these reasons were not good, or are no longer valid, you will have to remain. Under the circumstances, talking with me can only improve your chances of being released.” The interviewer must make it clear to the patient that although discussion may lead to his eventual release, there is no promise of immediate action. This honest approach will often enable the otherwise non-communicative psychotic paranoid patient to be interviewed.

The clinician can sympathize with the patient’s feeling of being mistreated. For example, a hospitalized psychotic paranoid woman who had been interviewed by several different clinicians earlier in the day began the interview by saying, “I have told my story to enough doctors, and I am tired and fed up and I am not going to talk to you!” When the interviewer sympathized with the patient’s feeling of injustice in being utilized in this way, the patient angrily continued, “Yes, and furthermore, the male patients who have jobs are excused to go to work and do not have to be subjected to these interviews.” This additional statement about the special treatment received by the male patients provided an opening for a sympathetic response, and within 2 or 3 minutes the patient was talking freely with the interviewer.

The more seriously ill psychotic paranoid patient who has frightening hallucinations and delusions is better motivated to communicate with the interviewer in order to obtain his protection; however, the pattern of the interview very quickly assumes the same characteristics as that with other paranoid persons.

The “Paranoid Stare”

The paranoid patient observes every detail of the interviewer’s behavior and of the surrounding environment. His “paranoid stare” makes many interviewers feel uncomfortable, and they may react by averting
their gaze from the patient's eyes. The patient is reassured if the interviewer watches him closely throughout the interview. Experiencing this as evidence of interest rather than mistrust, he is reassured that the interviewer is paying close attention and is not afraid of him.

The Filibuster

The interview with a paranoid patient is better described as a filibuster rather than an interaction between two participants. This filibuster is usually most pronounced in the opening and the closing phase of the interview. Since the paranoid person, like the obsessive person, experiences his greatest difficulty in establishing emotional contact and then in separating from another individual once contact has been made, it is easy to understand the adaptive value of this symptomatic behavior. By not allowing the other person to talk at the start of the interview, the patient controls the degree of his engagement in the relationship. Once he has developed emotional rapport, he must ward off the dangers of imminent rejection. He accomplishes this by rejecting the interviewer first, using words to keep him at a distance, but at the same time "hanging on" by continuing to speak.

A basic sense of worthlessness and inadequacy underlies the patient's attempt to dominate the therapist with his tirade of words. In order to permit engagement, the interviewer must allow the patient to tell his story. However, if this filibuster is permitted to continue throughout the interview, there will be no contact with the patient. Although one may occasionally confront this defense in the first interview with a comment such as "I have the feeling that I am being subjected to a filibuster," this technique will often alienate the patient. It is usually preferable to say, "I would like to hear the details of your story, and over the course of our sessions together I certainly will. However, there are issues that we must discuss now so that I may be able to help you." Another way to limit the patient's tirade without provoking him is to ask, "How can I be of help to you with these problems?" In this way the interviewer indicates that he will not be dominated by the patient, and he takes some control away from him. It may be necessary to repeat similar statements on more than one occasion during the interview if the patient attempts to reestablish the filibuster.

Denial

The paranoid person often refuses to accept the role of patient. This is a form of denial. For him the acceptance of this role implies a humiliating loss of dignity. If the interviewer attempts to force this person to admit
that he is a patient, it will further threaten an already tenuous balance of self-esteem. On the other hand, if he does not insist, the patient will often respond by demonstrating further psychopathology, once again inviting the interviewer to force him into the role of the patient. The interviewer, even though he recognizes and understands this cycle, should not interpret it to the patient during the early stages of treatment.

The patient who denies problems of his own and wants to discuss his delusional complaints, but who has come to the hospital voluntarily, offers an easy opportunity for engagement. After listening to the patient for 10-15 minutes, the clinician can say, “Since you have come to a hospital to consult a psychiatrist rather than the police, you must have had something in mind about how a psychiatrist could be helpful to you.” The patient’s attention is thereby directed away from the content of his delusions. He may indicate that he had already consulted the police and that they laughed at him or told him that he was crazy. Emotional rapport is facilitated if the interviewer empathizes with the patient’s predicament. For example, he might say to the patient, “It must have been terribly humiliating being treated in that way.”

**Mistrust**

The management of the patient’s mistrust and hostility becomes the crucial issue in conducting the interview. Beneath the patient’s hostility are deep wishes for, and also fears of, a close, trusting relationship. However any attempt at closeness with the paranoid patient leads to fear and mistrust, with further hostility. This occurs because of the patient’s fear of passivity and his conviction that only rejection can follow closeness, which is the reason that he wants to reject the clinician first. When the patient is not openly antagonistic and angry toward the interviewer, he will be distrustful and suspicious. The interviewer should refrain from assuring the patient that he is a friend, that he has come to help him, or that the patient can trust him as an ally. Instead, he can agree with the patient that he is a total stranger and that there is, indeed, no rational reason that the patient should immediately trust him or perceive him as an ally. The interviewer expresses his human compassion for the patient’s suffering without becoming his intimate friend. His relationship with the patient is real and authentic, but professional rather than personal.

The paranoid person has great difficulty in determining whom he can trust and whom he cannot trust. The interviewer’s recognition of the patient’s mistrust shows understanding of the problems. If the pa-
Patient accuses the interviewer of having wired the room, the patient could be given freedom to look about and check for himself. The interviewer might then pursue the patient's feeling that people are not trustworthy by asking him to relate experiences when he has been betrayed.

Nonpsychotic patients with paranoid personality traits express their mistrust of the clinician in more subtle ways. The psychodynamic issues involved are the same as those found in the more seriously disturbed patients. Some patients show their suspicion at the start of the interview. A patient may begin with a tone of firm conviction, "I was just curious, but did you leave that magazine on top of the pile so that I would see the cover story?" or "I think you left that picture crooked as a test!" The interviewer is advised to pursue these ideas further before providing an answer. He could reply, "What might I hope to learn from such a test?" One patient answered, "Oh, you could see if I am an aggressive type of woman who goes around straightening other people's pictures." Since the patient resisted her impulse, she felt that she had passed the test and therefore had no such problem. The interviewer did not challenge this view but mentally registered the incident in his evaluation of the patient.

Other patients evidence their suspicion and fear by attempting to keep "one up" on the interviewer. An example is the patient who says, "I'll bet I know why you asked me that question" or "I know what you're trying to do; you want to get me angry." If the interviewer explores the motives that the patient ascribes to him, he will uncover the power conflict and the patient's fear of being controlled. Persons with paranoid character traits tend to be secretive about revealing the names of former therapists or even friends whom they are discussing in the interview. The patient typically asks, "Why do you need to know that?" The interviewer can explore the patient's fear of damaging other persons as well as his fear of betrayal by the clinician. If the interviewer tries to pressure the patient into revealing such information, it only reinforces the patient's fear. It is more helpful if the interviewer interprets the patient's mistrust of him.

Demands for Action

On occasion, a paranoid psychotic patient may begin the interview not only with denial of any emotional problems but also with some bizarre demand based on his delusional thoughts. For example, a patient came to the emergency department complaining that he had been shot in the back. When the intern could find no evidence of a wound, he suggested psychiatric consultation. The patient, however, replied that he had been
shot with an invisible bullet and demanded a magnetic resonance imaging (MRI) scan be done. Attempts to establish rapport with such a patient by acceding to his outlandish demands are doomed to failure. Some part of the patient's ego maintains awareness of the irrational aspect of his request, and the clinician who humors the patient subjects him to later feelings of humiliation. Instead, the interviewer can indicate that the patient's perception is valid but that his interpretation is impossible. On might say, for example, "You feel that you have been wounded in the back, which is frightening, but there are several possible explanations for that feeling. I would not consider giving you an MRI; there are no invisible bullets." The inexperienced interviewer often expects that the patient will angrily leave the emergency room at this point; however, if the clinician is able to express his genuine interest with his tone of voice and attitude, the interview will then proceed.

A similar situation occurred with a patient who came to an emergency department demanding an X ray of his skull, claiming, "There is a cell phone in my brain." The patient was hallucinating, and again the relationship was enhanced by the clinician's indication that he was sincerely interested in aiding the patient but that he did not accept the patient's interpretation of his experience.

The interviewer is advised to limit his early confrontations concerning delusions to situations in which a patient demands immediate unreasonable action on the part of the interviewer. These demands can also be managed by exploring how the patient would feel if the X ray failed to confirm his belief. This will sometimes provide an opportunity for discussion of the problem that the patient attempts to deny with his delusions. The patient may then be able to express his fear that the voice may be a hallucination and therefore a reflection of mental illness.

It is sometimes necessary to accede to some unrealistic request on the part of a paranoid patient in order to establish an initial therapeutic relationship. For example, a paranoid patient entered the clinician's office and at once complained that he could not discuss his problems unless the interviewer pulled the window shade because he was being watched from the next building. The interviewer granted his request, but it became readily apparent that even though the shade was pulled, he still was not discussing his problem. When this was pointed out, the patient first became angry but then proceeded to reveal his difficulties. In these situations, the patient's demand is not as bizarre as those described earlier, and the interviewer set the stage for challenging the patient's rationalization by yielding to his request. One paranoid patient refused to be interviewed in a room where the partition did not go to the ceiling, even though he was assured that there was no one in the
adjacent room. The patient’s request for greater privacy was granted by moving to a different room.

A difficult problem is presented by the patient who refuses to be interviewed unless the clinician will promise not to hospitalize him. Obviously, no such blanket promise can be given. The interviewer might reply, “I do not believe in forcing treatment on someone against his will. Nevertheless, people who have uncontrollable impulses to harm themselves or others are treated in a hospital until they regain their own self-control.” Often this will reassure the patient at a deep level so that the interview can continue. If the patient has come voluntarily but further discussion convinces the interviewer that the patient would be best treated in a hospital, he should attempt to convince the patient to accept hospitalization, and if the patient still refuses, he can refuse to treat him unless he agrees. If the patient has been brought by someone else and these techniques fail, with the patient insisting on the promise before speaking, the interviewer could say, “If I do not hear the problem from you, I will have to base my decision exclusively on what your friends and relatives can tell me.”

Establishment of the Therapeutic Alliance

Challenging the Delusion

Every beginning clinician is tempted to argue the psychotic patient out of his delusional system by the use of logic. The impossibility of this task soon becomes apparent. It is more helpful if the interviewer asks the patient what is responsible for this persecution—why people should be against him and what he could possibly have done that offended them. The interviewer neither agrees with the delusions nor challenges them. The patient, however, usually interprets the interviewer’s interest as a sign of tacit agreement. It is essential for their later relationship that the interviewer makes no deceptive statements in order to gain the patient’s trust and confidence momentarily.

If the patient directly inquires whether the clinician believes his story, the interviewer could reply, “I know that you feel just as you say and that you are telling me the truth as you see it; however, the meaning that you attribute to your feelings is a matter for further clarification.” The interviewer might address himself to the patient’s anxiety about convincing the interviewer of the accuracy of his views so quickly and indicate that time is required to evaluate these problems. In general, the more bizarre the delusional material, the more open the interviewer must be in directly questioning the patient’s interpretation of his expe-
riences. In doing so, it is helpful for the interviewer to state the logical foundation behind his own position but to avoid debating it with the patient. Frequently, this involves a challenge to the patient’s grandiosity. For example, the clinician might say, “I have no doubt that the green car you described actually drove around the block; however I see no reason to believe that it contained foreign agents or that anyone in the car was interested in you more than anyone else. Nothing you have told me indicates why the foreign agents should consider you so important that they would bother to make your life difficult.”

The interviewer can often point out that the patient’s relatives disagree with his delusional system and that they believe their view just as strongly as the patient believes in his. He can then ask, “Why should I believe that you are right and that your relatives are crazy?” Any doubt or fluctuation in the patient’s feelings provides a foothold for establishing a therapeutic relationship. Later in treatment, increased or renewed delusional material should be traced to specific precipitating stresses.

**Differentiating Delusions From Reality**

Paranoid delusions often contain some kernel of truth. When the delusion is somewhat plausible, beginning interviewers often attempt to determine how much of the patient’s production is actually delusional and how much is real. This is an error, because it does not really matter exactly where reality begins and ends, and one can never actually make such a determination. It is far more important to establish rapport through the acknowledgment of the plausible elements of the delusion. The most important aspects of a delusion are the patient’s preoccupation with it, his irrational certainty that it is true, and its use to explain his frustrations, disappointments, and failures. The interviewer should suggest to the patient that his preoccupation with the delusion interferes with a constructive and useful life. In this manner, he can avoid arguments concerning the degree of truth in the delusion.

The interviewer inquires whether the patient has ever taken action or contemplated action based on his delusional system. It is important not to ask these questions in a tone that suggests that the patient should have taken action. The nature of any action that the patient did take will enable the interviewer to evaluate the patient’s judgment and impulse control.

**Developing the Treatment Plan**

It is important that the patient function as an active participant in the development of a treatment plan. Otherwise, he is likely to feel passive
and submissive and then express his resentment by not following the clinician's advice. To avoid this problem, the interviewer must stimulate the patient's motivation to receive help. The patient who is delusional may not feel that he requires treatment for his delusion but may willingly accept help aimed at his irritability, insomnia, or inability to concentrate. He might acknowledge a problem in his social life or on his job that could be treated with psychotherapy. Once the patient has indicated that he recognizes problems for which he desires help, the clinician can offer a tentative recommendation for treatment. Statements such as "These are problems we could work on together" or "I believe I can help you to arrive at a solution to this difficulty" emphasize that the patient plays an active role in treatment and is not merely submitting to the clinician. If the therapist is overly enthusiastic in offering therapeutic recommendations, the patient is more likely to resist them.

When it is necessary to refer a paranoid patient to another therapist, the clinician can anticipate trouble. The patient will often question the qualifications of the therapist to whom he is referred. The interviewer can review these qualifications and then ask, "Did you think I would send you to someone not adequately qualified?" The patient will usually hasten to reassure the interviewer that he had no such thought. The interviewer could then comment, "Perhaps you feel hurt or angry that I do not have time to work with you myself." If the patient acknowledges such feelings and the interviewer is not defensive, the referral is more likely to proceed smoothly. If the patient denies such feelings, the interviewer can expect a call from the patient saying that he did not like the new clinician for a variety of reasons. In general, the interviewer should advise the patient to go back to the other clinician and discuss these feelings with him, rather than send the patient to still another therapist.

The psychotic paranoid patient is hypersensitive to restrictions of freedom or situations of enforced passivity. He does not readily accept medication or hospitalization. The interviewer should not bring up these subjects until he has established a trusting relationship with the patient. When hospital treatment is required, every attempt should be made to convince the patient to accept voluntary hospitalization, avoiding physical or social coercion. The psychotic paranoid patient’s fear that others will exert influence over his behavior extends into the area of medication. The clinician who hands a prescription to the patient and says, "Take this according to the directions" will have little success. Instead, the clinician might advise the patient concerning the name of the medication as well as the therapeutic action and possible side effects to be expected. He can then ask the patient if there are any questions con-
cerning the prescription. The patient is now a partner in planning the treatment and is more likely to work for its success.

**Maintaining Openness and Consistency**

The therapist works to establish a relationship with the remaining healthy portion of the patient's ego. It is not the patient's delusional system that requires treatment but the frightened, angry person who has created it. Firmness and steadiness characterize the secure therapist's attitude. The patient should be granted no special favors or privileges, and the clinician must maintain the most scrupulous honesty at all times. The punctuality, predictability, and consistency of the therapist's behavior are of great importance in enabling this patient to develop a trusting relationship. When a paranoid person is treated on an outpatient basis, a clear statement about the rules of treatment, the charges for missed sessions, and so on will help prevent misunderstandings that otherwise may threaten the therapy. For example, this patient can easily make the clinician angry by not respecting his personal rights or property.

The clinician does not help the patient by allowing him to intrude into his private life or to abuse the furniture in his office. The interviewer may sympathize directly with the patient's hate of hypocrisy, inconsistency, and unpredictability. Accurate perceptions should be reinforced, including perceptions about the interviewer, even though these may be negative. At all times, the interviewer must be forthright about areas of disagreement, making statements to the patient such as "We can agree to disagree." Such statements underline that the patient and interviewer each have their own identity. Whenever possible, the therapist can emphasize and support the patient's right and ability to make his own decisions.

**Managing Anxiety in the Therapist**

Some therapists have such strong dislike or fear of paranoid patients that they should not treat them until these problems are resolved. If the therapist is frightened of the patient's potential assaultiveness, he should conduct the interview only in the presence of an attendant or other adequate safeguard.

The paranoid patient tends to disrupt his relationship with the therapist as he has done with significant persons in the past, first by making him anxious and then by perceiving his reaction as a rejection. The therapist must understand that there is some validity in the patient's complaints. The paranoid patient requires a secure therapist whose self-
esteem is not challenged by angry, and at times accurate, criticisms.

When the patient expresses hostile, critical feelings, the therapist who needs to be liked and appreciated will feel hurt and will respond with anger or withdrawal. When the patient expresses positive feelings, this therapist will accept the benevolent parental role that the patient ascribes to him, thereby inflating the clinician's ego and infantilizing the patient.

The interviewer may advise the paranoid patient that, in due time, he will grow suspicious of the therapist but that this does not justify terminating the relationship. Instead, it is an indication for exploration, improved communication, and a better mutual understanding of the clinician's and the patient's feelings. Because of the patient's extreme sensitivity to rejection, he must be prepared long in advance for any vacation or absence from treatment on the part of the therapist.

Infinite patience is required in order to tolerate the continuing mistrust and suspiciousness that are directed at the therapist. The patient's extreme sensitivity to criticism and his alternation between clinging submissive ingratiation and defensive aggression often stimulate anger in the therapist.

Avoiding Humor

The paranoid person thinks of himself as having a good sense of humor. In actuality, he lacks the ability to reflect on himself, to relax, and to accept the subtlety and ambiguity required for true humor. His sardonic laugh reflects his pleasure in the sadism or aggression in a situation, but more complex types of humor are beyond his grasp. The interviewer therefore should avoid witty or humorous remarks, particularly if they are directed at the patient, because this person has no sense of humor about anything applied to himself. He reacts to such attempts, no matter how skillfully conducted, as though the interviewer were making fun of him. Irony and metaphor are also dangerous, because the patient's concreteness makes him likely to miss the desired meaning.

The most frequent joke attempted by the therapist is an exaggeration of the paranoid patient's tendency to be suspicious or mistrustful. If the "clever" sarcastic remarks of the paranoid patient are returned in kind, the patient feels hurt and misunderstood. For example, a paranoid patient made sarcastic, humorous remarks about her therapist's scheduling her appointments during the lunch hour. The interviewer misperceived the meaning of the patient's "jokes" and quipped, "The next thing I know, you'll be accusing me of trying to starve you." Not long thereafter, the patient developed a delusion that the therapist was
plotting her starvation. The inexperienced clinician displays his anxiety and unconscious hostility to the patient with such remarks.

Avoiding Inappropriate Reassurance

The interviewer sometimes offers inappropriate reassurance prior to understanding the patient's specific fears. For example, an obviously psychotic paranoid patient began an interview by asking a resident psychiatrist, "Do I seem 'crazy' to you?" The resident replied that he did not, thereby hoping to foster a supportive therapeutic relationship. Although some initial rapport was established by this method, the clinician soon learned that the patient had many crazy thoughts and feelings. By allowing himself to be manipulated, the clinician appeared naive and foolish in the patient's eyes. It would have been better had he said, "What makes you ask if you are crazy?" or "Let's talk and see if there is anything crazy." The patient was testing the clinician to determine his willingness to admit uncertainty. The clinician's lack of hypocrisy, despite the coercive pressure for an insincere reply, would have been comforting.

Use of Interpretations

Understanding the Importance of Timing

Interpretations are intrusions in the patient's life, and paranoid persons are unable to tolerate intrusion. Clarification or explanations may be offered early in treatment, but interpretations must be delayed until a trusting relationship has developed.

Dynamic interpretations of grossly psychotic paranoid distortions must wait until the psychosis has improved. However, it is necessary to stimulate doubt and uncertainty in the patient's mind concerning his delusional systems. Teaching the patient to consider alternate explanations of his observations undermines his projective defenses. As an example, a patient reported that people in the apartment across the street were making videotapes of him. The therapist agreed that there might indeed be people across the street making videotapes but suggested that there might be other explanations of what was being filmed. When the patient argued that the purpose of the filming was to obtain evidence concerning his sexual practices, the clinician inquired whether the patient felt embarrassed and ashamed about his sex life. This was, in fact, the case, and it initiated a discussion of a major problem area.

Interpretations directed at the role the patient plays in bringing about his own misfortunes must be slow, gentle, and tentative. This
topic can easily precipitate severe anxiety with total loss of self-esteem and overwhelming depression, a constant problem for the paranoid patient. When the patient does achieve some insight into this aspect of his behavior, he experiences a sense of acute panic and feels that the problem must be resolved magically, immediately, and permanently. For example, a therapist interpreted that the patient’s fear of male figures of authority had caused him to behave provocatively with his boss. During the following session he reported, “Well, I have now solved that problem of being afraid of my father.” Further exploration was thereby closed off. This makes any “uncovering” approach to psychotherapy difficult with a paranoid patient. The patient is unable to live up to his ego ideal and feels intense shame whenever the discrepancy is brought to his attention.

Early in treatment, the therapist can offer interpretive comments that are aimed at reducing the patient’s guilt, even though the patient denies any feeling of guilt. The paranoid person is tortured by unconscious feelings of guilt, and such comments reduce his need to project his self-contempt onto others. Some early clarification of the patient’s continuing search for closeness and his intense fear of it may be productive. Exploration of the patient’s unconscious fears of homosexuality is best not pursued in the early or middle phases of therapy if they are not brought up by the patient and if the patient is able to deny the significance of such material.

Interpreting the Transference

When the patient produces fantasy material about the therapist in the early stages of treatment, it is helpful to provide appropriate realistic data and then to explore how the patient came to his own conclusions. An analysis of the paranoid patient’s transference fantasies while the therapist remains anonymous is doomed to failure.

As a positive relationship evolves, the paranoid patient typically develops an unrealistic overestimation of his clinician as omniscient and omnipotent. The interviewer can diminish this projection of the patient’s grandiosity by occasionally dropping specific data about himself that challenge the patient’s idealized distortion. For instance, a paranoid man indicated that the clinician was always fair and reasonable. The therapist reminded the patient that he had once overheard the therapist speaking impatiently to the doorman. Another patient made a reference to a historical novel and the therapist indicated that he had not read that book. The patient immediately offered excuses for the clinician’s ignorance, but the therapist remarked, “You have uncovered an
area in which I am not well informed, and you seem reluctant to accept my deficiency." This technique can stimulate disturbing fantasies and must be utilized with caution and never early in treatment.

The interviewer can indicate to the paranoid patient that his recognition of slights may be quite accurate but that his interpretation of motives may be quite erroneous. The paranoid person views the world as though people had no unconscious motives and all acts were deliberate. The patient's accusations may pertain to the motivation of the interviewer. One of us had a patient who became justifiably angry when he found that the clinician had forgotten to leave the waiting room door unlocked and suggested that this was evidence of the therapist's wish to get rid of him. The therapist responded by admitting that he had left the waiting room door locked, thereby supporting the patient's right to be angry, but then added, "You are certainly entitled to analyze me if you wish to do so; however, isn't it only fair that you find out what I think happened and how I feel about it before jumping to conclusions concerning my motives?" In this way, the interviewer not only addressed himself to the patient's feeling of righteous indignation but also established a foundation for analyzing the patient's projective defenses. Every opportunity for the patient to expand his awareness of how he makes conclusions about the motives of others without adequate information has a therapeutic effect. It was later explained that the clinician was unlocking his front door when the telephone rang. He rushed to answer the phone, leaving the door ajar but still locked. A passerby closed the door, and soon thereafter the patient arrived. It is helpful to the paranoid patient for the clinician to show him that other factors in the interviewer's life not related to the patient may at times affect his mood and his treatment of the patient.

The therapist must be tolerant of the patient's overreactions to mistakes and shortcomings, an attitude that is the opposite of that expressed by the patient's parents. It is common for the patient to collect a series of minor grievances and temporarily withhold them from the therapist. He will often confront the clinician much later with something that the patient misinterpreted as a slight, quoting the therapist's exact words. While he keeps his injuries secret, the patient may feel superior to his therapist. The patient's tendency to withhold his resentments makes exploration and understanding impossible.

The paranoid patient attempts to maintain a one-up position by anticipating the clinician's behavior and interpretations, and he defends himself from their impact by analyzing the motivation behind the therapist's comments. The patient's eventual awareness of his underlying grandiosity and its role as a defense against feelings of worthlessness
and inadequacy is only the beginning. It allows exploration of the developmental problems that led to the development of such defenses. The introduction of reality into the treatment process provides an important therapeutic lever. However, in discussing the patient’s delusional system in terms of reality, the therapist must protect the patient from feeling humiliated.

The Dangerous Patient

The assessment of homicidal risk is in many ways quite similar to the assessment of suicidal risk. As with the suicidal patient, the interviewer inquires if the patient has formulated a specific plan as to how he would commit the murder and whether he has taken any action toward the implementation of this plan. The interviewer might ask if he has had similar feelings in the past and how he managed to overcome them on those occasions. A family history of murder or sadistic beating is of importance. Inquiry into past episodes in which the patient had lost control of aggressive impulses and the outcome of these episodes provides important data. A past history of vengeful, destructive behavior indicates that the patient may require external control. In this regard, the interviewer could inquire if the patient has ever caused anyone’s death. A history of torturing and killing animals in childhood is pertinent to the assessment of homicidal risk. Such behavior is frequently found in the history of people who kill others. Precipitating stress is important in understanding the development of destructive impulses. When specific stresses can be uncovered, the clinician has a greater opportunity to recommend helpful manipulations of the patient’s environment. Persons accompanying the patient, including police officers, should always be interviewed. Often the homicidal significance of the behavior is denied by the patient’s relatives and professional personnel as well.

The interviewer should realize that it is possible to assassinate anyone. The patient who is unambivalent concerning his homicidal impulses is not likely to be interviewed by the clinician, or at least he will not mention these feelings. If the patient brings the subject up for discussion, this is already evidence that he has not completely decided to commit murder and may therefore be influenced away from this course of action. The interviewer can interpret that the patient is frightened and upset at the possibility of becoming a murderer and comment on the predicament in which the patient finds himself. The therapist offers to help the patient understand the reasons behind his desire to commit murder and to help the patient obtain additional control in restraining
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his impulses if needed. The latter may be in the form of medication or temporary hospitalization until the patient feels more capable of controlling himself. If the interviewer has evidence of homicidal intent, for example, if the patient states that he intends to kill someone for whatever reason, delusional or not, the confidentiality of the interview no longer applies. The clinician is legally bound to inform both the putative victim and the legal authorities of this declared intent. The patient should be informed that this action has to be taken because it is mandated by law.

A 17-year-old adolescent was brought to the emergency department by his parents because he had become reclusive and refused to attend school. He had been seen obtaining information on firearms from the Internet and would sometimes lock himself in his room for hours. In the interview he was sullen and withdrawn, responding evasively when asked about violent or aggressive impulses. A history of fire setting and cruelty to animals was elicited from the parents. On one occasion he had almost choked another boy. He repeatedly denied any need for treatment and asked to be allowed to return home. The interviewer told the patient, “I have the uneasy feeling that you may be planning to kill someone.” The patient did not reply but looked away from the interviewer. The clinician continued, “Under the circumstances, I feel that you belong in a hospital until I am convinced that you are well enough to return home.” On other occasions, the interviewer’s admission of discomfort with the patient would facilitate the interview. He might say to the patient, “If you are trying to scare me, you are succeeding. I can’t help you if you put me in this position, so let’s try and find out why you need to do this!”

It is worthwhile to remember that the patient who threatens the life of a clinician often behaves in this fashion because he is afraid. The interviewer who realizes that the patient is more anxious than he is has a distinct advantage. For example, a frightening incident occurred when one of us, as a fourth-year medical student, had started to deliver a baby at the mother’s home. The expectant father suddenly burst into the room, intoxicated and waving a pistol. He shouted, “The baby better be OK, Doc!” The student physician started to pack up his equipment and said, “If you don’t put down that gun and leave immediately, I will leave your wife and not deliver the baby.” The man put down the gun and left without further trouble.

Although a paranoid patient may be assultive in initial interviews, it is rare for him to harbor specific homicidal impulses toward his therapist until treatment has progressed. It is easy to panic when a patient announces that he is formulating a plan to kill the therapist or some
member of his family. It can be devastating for the patient if the interviewer panics and calls the police behind the patient’s back, arranging for him to be hospitalized under force. The arrangements for hospitalization must be openly discussed, with the patient under constant observation, until they can be implemented. If the patient indicates that he is carrying a weapon, the clinician should ask him to relinquish it until the patient has reestablished confidence in his ability to control himself. The therapist might well remember that the patient fears he will be rejected because of his intense homicidal impulses. The therapist’s ability to accept the patient in spite of these feelings will often lead to their prompt amelioration.

CONCLUSION

As this chapter has shown, the paranoid patient presents multiple challenges to the interviewer. Gradually, as psychotherapeutic treatment progresses, these patients can develop some understanding of how their attitudes and behavior affect others. As they learn to trust the support and affection of their therapist, they can then appreciate that life is not always black or white and that people are able to genuinely care about them without their becoming the center of their universe.