UNIT 2 PARANOID AND DELUSIONAL DISORDER

Structure

2.0 INTRODUCTION

This unit deals with paranoia and delusional disorder. We start with the concept of paranoia, define paranoia and describe the characteristic features of the same. Then we

delineate the symptoms of paranoia and the kinds of paranoia that are obtained in this disorder. This is followed by Causes of paranoia wherein we deal with various factors including feelings of inferiority, emotional complex, personality type, hereditary factors, biological factors, environmental and psychological factors. We also mention the medical causes, other mental illnesses and substance abuse as a cause. Then we discuss delusional disorder. Delineating the characteristic features of this disorder we deal with the various types of delusional disorders especially the grandiose, erotomaniac etc., and then deal with the motivated or defensive delusions. Since delusion are obtained in various other psychiatric disorders, these aspects are then considered followed by the treatment approach to the paranoia and delusional disorders. We end up with the prognosis of these disorders.

2.1 OBJECTIVES

On completing this unit, you will be able to:

- Define paranoia and delusional disorders;
- Enlist various types of paranoia delusional disorders;
- Elucidate the Symptoms and causes of the disorders;
- Explain the Interventional approaches for the delusional disorders; and
- Analyse the prognosis.

2.2 CONCEPT OF PARANOIA

2.2.1 Definition of Paranoia

Here the patient becomes a prey to premature delusion. According to Kraeplein, in the disease the cause of delusion is internal, and no hallucination is involved.

A paranoid disorder is a medical illness, which happens to affect the brain, and causes changes in thinking and feeling. It's nobody's fault when it develops, and certainly does not mean any personal weakness or failure. It's an illness just as diabetes and asthma are illnesses.

It's not all that uncommon, either Paranoia disorder consists of pervasive, long-standing suspiciousness and generalised mistrust of others. Those with the condition are hypersensitive, are easily slighted, and habitually relate to the world by vigilant scanning of the environment for clues or suggestions to validate their prejudicial ideas or biases.

Paranoid individuals are eager observers. They think they are in danger and look for signs and threats of that danger, disregarding any facts. They tend to be guarded and suspicious and have quite constricted emotional lives. Their incapacity for meaningful emotional involvement and the general pattern of isolated withdrawal often lend a quality of schizoid isolation to their life experience.

Despite the pervasive suspicions they have of others, patients are not delusional (except in rare, brief instances brought on by stress). Most of the time, they are in touch with reality, except for their misinterpretation of others' motives and intentions.

Paranoid Personality Disorder patients are not psychotic but their conviction that others are trying to "get them" or humiliate them in some way often leads to hostility and social isolation.

The word *paranoia* comes from the Greek word *indicating* madness and the term was used to describe a mental illness in which a delusional belief is the sole or most prominent feature. In original attempt at classifying different forms of mental illness, Kraepelin used the term *pure paranoia* to describe a condition where a delusion was present, but without any apparent deterioration in intellectual abilities and without any of the other features of dementia praecox, the condition later renamed "schizophrenia".

Notably, in his definition, the belief does not have to be persecutory to be classified as paranoid, so any number of delusional beliefs can be classified as paranoia. For example, a person who has the sole delusional belief that he is an important religious figure would be classified by Kraepelin as having pure paranoia.

Even at the present time, a delusion need not be suspicious or fearful to be classified as paranoid. A person might be diagnosed as a paranoid schizophrenic without delusions of persecution, simply because their delusions refer mainly to themselves.

2.2.2 Characteristic Features of Paranoia

People with this disorder do not trust other people. In fact, the central characteristic of people is a high degree of mistrustfulness and suspicion when interacting with others. Even friendly gestures are often interpreted as being manipulative or malevolent.

Whether the patterns of distrust and suspicion begin in childhood or in early adulthood, they quickly come to dominate the lives of those suffering from the said disorder. Such people are unable or afraid to form close relationships with others. They suspect strangers, and even people they know, of planning to harm or exploit them when there is no good evidence to support this belief. As a result of their constant concern about the lack of trustworthiness of others, patients with this disorder do not have intimate friends or close human contacts. They do not fit in and they do not make good "team players."

Interactions with others are characterised by wariness and not infrequently by hostility. If they marry or become otherwise attached to someone, the relationship is often characterised by pathological jealousy and attempts to control their partner. They often assume their sexual partner is "cheating" on them. People suffering from this disorder are very difficult to deal with. They never seem to let down their defenses. They are always looking for and finding evidence that others are against them.

Their fear, and the threats they perceive in the innocent statements and actions of others, often contributes to frequent complaining or unfriendly withdrawal or aloofness. They can be confrontational, aggressive and disputatious. It is not unusual for them to sue people they feel have wronged them. In addition, patients with this disorder are known for their tendency to become violent. Individual counseling seems to work best but it requires a great deal of patience and skill on the part of the therapist. Phelan, M. Padraig, W. Stern, J (2000) paranoia and paraphrenia are debated entities that were detached from dementia praecox by Kraepelin, who explained paranoia as a continuous systematized delusion arising much later in life with no presence of either hallucinations or a deteriorating course, paraphrenia as an identical syndrome to paranoia but with hallucinations.

2.2.3 Symptoms of Paranoia

The main symptom is permanent delusion. It should be kept in mind that there is delusion in schizophrenia also but in that case it is not permanent or organised. In paranoia the symptoms of delusion appear gradually, and the patient is sentimental, suspicious, irritable,

introverted, depressed, obstinate, jealous, selfish, unsocial and bitter. Hence his social and family adjustment is not desirable, and while he has the highest desirable, the effort that he is prepared to expend is correspondingly little. Here the person does not acknowledge his own failures or faults, and by sometimes accepting certain qualities as belonging to himself, even when imaginary, he develops paranoia.

The "Diagnostic and Statistical Manual of Mental Disorders", fourth edition (DSM-IV), the US manual of the mental health professional; lists the following symptoms for paranoid personality disorder:

- Preoccupied with unsupported doubts about friends or associates.
- Suspicious; unfounded suspicions; believes others are plotting against him/her.
- Perceives attacks on his/her reputation that are not clear to others, and is quick to counterattack.
- Maintains unfounded suspicions regarding the fidelity of a spouse or significant other.
- Reads negative meanings into innocuous remarks.
- Reluctant to confide in others due to a fear that information may be used against him/her.
- Self-referential thinking:Sensing that other people in the world are always talking about the paranoid individual.
- Thought broadcasting: The sense that other people can read the paranoid individual's mind.
- Magical thinking: The sense that the paranoid individual can use his or her thoughts to influence other people's thoughts and actions.
- Thought withdrawal: The sense that people are stealing the paranoid individual's thoughts.
- Thought insertion: The sense that people are putting thoughts into the paranoid individual's mind.
- Ideas of reference: The sense that the television and/or radio are specifically addressing the paranoid individual.

2.2.4 Kinds of Paranoia

Persecutory paranoia : This is the most prevalent type of paranoia, and in this patient makes himself believe that all those around him are his enemies, bent on harming him or even taking his life. In this delusion people of an aggressive temperament often turns dangerous killers.

Religious paranoia : Here the patients suffer from a permanent delusion of a primarily religious nature. He for example believes, that he is the messenger of God who has been sent to the world to propagate some religion.

Reformatory paranoia : In this the patient turns to considering himself a great reformer. He accordingly looks upon all those around him. As suffering from dangerous disease, and believes that he is their reformer and curator.

Erotic paranoia : Here the patient often tends to believe that some members of the family of the opposite sex, belonging to an illustrious family, want to marry him. Such people even write love letters and there by, cause much botheration to other people.

Litigious paranoia : In this kind the patient takes to feeling meaningless cases against other people and feels that people are linked together to bother him. Sometimes he, even tries to murder.

Hypochondrical paranoia : In this kind the patients believes that he is suffering from all kind of ridiculous diseases, and also that some other people are to blame for his suffering.

Self Assessment Qeustions

1) Define Paranoia and bring out the characteristic features of this disorder.

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2) What are the symptoms of paranoia?

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3) What are the different kinds of paranoia?

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2.3 CAUSES OF PARANOIA

2.3.1 Homosexual Fixation

According to Freud, the patient suffering from the disease has repressed his tendency to homosexual love to such an extent that he develops a fixation concerning it. Freud's view has been found correct in many cases, but it does not explain each and every case of the disease.

2.3.2 Feelings of Inferiority

Here the psychologists have found that the main cause of paranoia is a sense of inferiority that may be caused by a variety of condition such as failure, disgust, sense of guilt.

2.3.3 Emotional Complex

Certain psychologist points out emotional complexes, and also believe that they are seen to be present in other mental diseases as also in normal individuals.

2.3.4 Personality Type

Cameron believes a certain type to be more susceptible to this disease, a personality that has sentimentally, jealousy, suspicion, ambition, selfishness and shyness etc. Patients of paranoia do exhibit these peculiarities of personality but on this basis they cannot be said to belong to definite personality.

2.3.5 Heredity

In the opinion of Fisher the main responsibility of paranoia lies fairly and squarely upon heredity, although he does not deny the importance of repression and emotional complexes.

The causes of paranoia are not physical because no patient exhibits any signs of physical deformity and among the causes there are many important" ones, such as defects of personality, sense of inferiority, repression etc.

2.3.6 Biological

Researchers are studying how abnormalities of certain areas of the brain might be involved in the development of delusional disorders. An imbalance of certain chemicals in the brain, called neurotransmitters, also has been linked to the formation of delusional symptoms. Neurotransmitters are substances that help nerve cells in the brain send messages to each other. An imbalance in these chemicals can interfere with the transmission of messages, leading to symptoms.

2.3.7 Environmental/Psychological

Evidence suggests that delusional disorder can be triggered by stress. Alcohol and drug abuse also might contribute to the condition. People who tend to be isolated, such as immigrants or those with poor sight and hearing, appear to be more vulnerable to developing delusional disorder.

2.3.8 Dysfunctional Cognitive Processing

An elaborate term for thinking is "cognitive processing." Delusions may arise from distorted ways people have of explaining life to themselves. The most prominent cognitive problems involve the manner in which delusion sufferers develop conclusions both about other people, and about causation of unusual perceptions or negative events.

Studies examining how people with delusions develop theories about reality show that the subjects have ideas which which they tend to reach an inference based on less information than most people use.

This "jumping to conclusions" bias can lead to delusional interpretations of ordinary events. For example, developing flu-like symptoms coinciding with the week new neighbours move in might lead to the conclusion, "the new neighbours are poisoning me."

The conclusion is drawn without considering alternative explanations—catching an illness from a relative with the flu, that a virus seems to be going around at work, or that the tuna salad from lunch at the deli may have been spoiled.

Additional research shows that persons prone to delusions "read" people differently than non-delusional individuals do. Whether they do so more accurately or particularly poorly is a matter of controversy.

Delusional persons develop interpretations about how others view them that are distorted. They tend to view life as a continuing series of threatening events. When these two aspects of thought co-occur, a tendency to develop delusions about others wishing to do them harm is likely.

2.3.9 Medical Causes

Many medical conditions can lead to paranoid thoughts. Alzheimer's disease, chemical deficiencies, cathinone poisoning and neurological degeneration disorders can harm the nervous system and lead to confusion and unstable emotions. Sufferers of these conditions sometimes forget who they can trust and also lose the ability to differentiate between trustworthy and suspicious behaviour.

2.3.10 Associated Mental Illnesses

Some mental illnesses are associated with paranoia. An inability to think clearly can cause an individual to lose the ability to differentiate between trustworthy and not trustworthy individuals. Schizophrenia causes an individual to have bizarre or disorganised thoughts. Some individuals hallucinate and begin to believe that which they hallucinate rather than their friends and family members. Psychosis involves a detachment from reality that can lead to paranoid thoughts.

2.3.11 Substance Abuse

Many substances lead to paranoia if abused: alcohol, amphetamines, crack, crystal meth, cocaine, ecstasy, marijuana, narcotics, opioids, opium, pain killers, oxycodone, sleeping pills and tranquilizers. Withdrawal from many of these substances can also trigger paranoid thoughts, so withdrawal must be handled carefully with close supervision.

Self Assessment Questions

1) What are the causes of paranoia?

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2) Discuss feelings of inferiority and emotional complex as causes of paranoia.

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3) Delineate the hereditary factors and biological factors as causes of paranoia.

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4) What is dysfunctional cognitive processing?

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5) What are the medical causes and associated mental illnesses as causes of paranoia?

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2.4 DELUSIONAL DISORDER

Delusions are irrational beliefs, held with a high level of conviction, that are highly resistant to change even when the delusional person is exposed to forms of proof that contradict the belief.

Non-bizarre delusions are considered to be plausible; that is, there is a possibility that what the person believes to be true could actually occur a small proportion of the time. Conversely, bizarre delusions focus on matters that would be impossible in reality. For example, a non-bizarre delusion might be the belief that one's activities are constantly under observation by federal law enforcement or intelligence agencies, which actually does occur for a small number of people.

By contrast, a man who believes he is pregnant with German Shepherd puppies holds a belief that could never come to pass in reality. Also, for beliefs to be considered delusional, the content or themes of the beliefs must be uncommon in the person's culture or religion. Generally, in delusional disorder, these mistaken beliefs are organised into a consistent world-view that is logical other than being based on an improbable foundation.

2.4.1 Characteristic Features

Unlike most other psychotic disorders, the person with delusional disorder typically does not appear obviously odd, strange or peculiar during periods of active illness. Yet the person might make unusual choices in day-to-day life because of the delusional beliefs. Expanding on the previous example, people who believe they are under government observation might seem typical in most ways but could refuse to have a

telephone or use credit cards in order to make it harder for "those Federal agents" to monitor purchases and conversations.

Most mental health professionals would concur that until the person with delusional disorder discusses the areas of life affected by the delusions, it would be difficult to distinguish the sufferer from members of the general public who are not psychiatrically disturbed. Another distinction of delusional disorder compared with other psychotic disorders is that hallucinations are either absent or occur infrequently.

The person with delusional disorder may or may not come to the attention of mental health providers. Typically, while delusional disorder sufferers may be distressed about the delusional "reality," they may not have the insight to see that anything is wrong with the way they are thinking or functioning. Regarding the earlier example, those suffering delusion might state that the only thing wrong or upsetting in their lives is that the government is spying, and if the surveillance would cease, so would the problems.

Similarly, the people suffering the disorder attribute any obstacles or problems in functioning to the delusional reality, separating it from their internal control. Furthermore, whether unable to get a good job or maintain a romantic relationship, the difficulties would be blamed on "government interference" rather than on their own failures or omissions.

Unless the form of the delusions causes illegal behaviour, somehow affects an ability to work, or otherwise deal with daily activities, the delusional disorder sufferer may adapt well enough to navigate life without coming to clinical attention. When people with delusional disorder decide to seek mental health care, the motivation for getting treatment is usually to decrease the negative emotions of depression, fearfulness, rage, or constant worry caused by living under the cloud of delusional beliefs, not to change the unusual thoughts themselves.

Delusional disorder, previously called paranoid disorder, is a type of serious mental illness called a "psychosis" in which a person cannot tell what is real from what is imagined. The main feature of this disorder is the presence of delusions, which are unshakable beliefs in something untrue.

People with delusional disorder experience non-bizarre delusions, which involve situations that could occur in real life, such as being followed, poisoned, deceived, conspired against, or loved from a distance. These delusions usually involve the misinterpretation of perceptions or experiences. In reality, however, the situations are either not true at all or highly exaggerated.

People with delusional disorder often can continue to socialise and function normally, apart from the subject of their delusion, and generally do not behave in an obviously odd or bizarre manner. This is unlike people with other psychotic disorders, who also might have delusions as a symptom of their disorder. In some cases, however, people with delusional disorder might become so preoccupied with their delusions that their lives are disrupted.

Psychiatrists make a distinction between the milder paranoid personality disorder described above and the more debilitating delusional (paranoid) disorder. The hallmark of this disorder is the presence of a persistent, nonbizarre delusion without symptoms of any other mental disorder.

Delusions are firmly held beliefs that are untrue, not shared by others in the culture, and not easily modifiable. Five delusional themes are frequently seen in delusional disorder. In some individuals, more than one of them is present.

Whether or not persons with delusional disorder are dangerous to others has not been systematically investigated, but clinical experience suggests that such persons are rarely homicidal. Delusional patients are commonly angry people, and thus they are perceived as threatening. In the rare instances when individuals with delusional disorder do become violent, their victims are usually people who unwittingly fit into their delusional scheme. The person in most danger from an individual with delusional disorder is a spouse or lover.

2.4.2 Types of Delusional Disorder

Paranoia is an unfounded or exaggerated distrust of others, sometimes reaching delusional proportions. Paranoid individuals constantly suspect the motives of those around them, and believe that certain individuals, or people in general, are "out to get them."

Paranoid perceptions and behaviour may appear as features of a number of mental illnesses, including depression and dementia, but are most prominent in three types of psychological disorders: paranoid schizophrenia, delusional disorder (persecutory type), and paranoid personality disorder (PPD).

Individuals with paranoid schizophrenia and persecutory delusional disorder experience what is known as persecutory delusions: an irrational, yet unshakable, belief that someone is plotting against them. Persecutory delusions in paranoid schizophrenia are bizarre, sometimes grandiose, and often accompanied by auditory hallucinations. Individuals with delusional disorder may seem offbeat or quirky rather than mentally ill, and, as such, may never seek treatment.

Persons with paranoid personality disorder (PPD) tend to be self-centered, self-important, defensive, and emotionally distant. Their paranoia manifests itself in constant suspicions rather than full-blown delusions. The disorder often impedes social and personal relationships and career advancement. Some individuals with PPD are described as "litigious," as they are constantly initiating frivolous law suits. PPD is more common in men than in women, and typically begins in early adulthood.

The exact cause of paranoia is unknown. Potential causal factors may be genetics, neurological abnormalities, changes in brain chemistry, and stress. Paranoia is also a possible side effect of drug use and abuse (for example, alcohol, marijuana, amphetamines, cocaine, PCP). Acute, or short term, paranoia may occur in some individuals overwhelmed by stress.

The diagnosis of patients with paranoid symptoms includes a thorough physical examination and patient history to rule out possible organic causes (such asdementia) or environmental causes (such as extreme stress). If a psychological cause is suspected, a psychologist will conduct an interview with the patient and may administer one of several tests to evaluate mental status.

Paranoia that is symptomatic of paranoid schizophrenia, delusional disorder,or paranoid personality disorder should be treated by a psychologist and/or psychiatrist. **Antipsychotic** medication such as thioridazine (Mellaril),haloperidol (Haldol), chlorpromazine (Thorazine), clozapine (Clozaril), or risperidone (Risperdal) may be prescribed, and cognitive therapy or psychotherapy may be employed to help the patient cope with their paranoia and/or persecutory delusions. It is uncertain whether antipsychotic medication benefit individuals with paranoid personality disorder and may even pose long-term risks.

If an underlying condition, such as depression or drug abuse, is found to be triggering the paranoia, an appropriate course of medication and/or psychosocial therapy is employed to treat the primary disorder.

Because of the inherent mistrust felt by paranoid individuals, they often must be coerced into entering treatment. As unwilling participants, their recovery may be hampered by efforts to sabotage treatment (for example, not taking medication or not being forthcoming with a therapist). They may also exhibit a lack of insight into their condition or the belief that the therapist is plotting against them. Although their lifestyles may be restricted, some patients with PPD or persecutory delusional disorder continue to function in society without treatment.

Distrust is the hallmark of delusional disorder. Someone who suffers from this disorder is very defensive, sometimes to the point of being aggressive, and may constantly question the motives of others. Even if people appear harmless on the surface, the patient believes that they are simply trying to lull the patient into a sense of complacency, and the patient will remain on guard as a result. Other symptoms of delusional disorder can include a sense of social isolation caused in part by the patient's defensive and suspicious behaviour, and a lack of humor.

2.4.3 Delusion of Grandeur

In this patient believes himself to be, a great individual, and according to Bleuler, this delusion of grandeur accompanies a persecutory delusion. A delusion is (common in paranoia) that you are much greater and more powerful and influential than you really are.

One of the toughest psychiatric anomalies both to diagnose and treat is delusion disorder like delusion of grandeur, delusional paranoid, even delusional jealousy. The reason why diagnosis can be tough is the person is often working quite typically in the world. The delusions in this disorder are non bizarre, meaning that they can essentially be plausible even if they are not true. Those suffering from this disorder often will not believe they have a problem, so it is difficult to get them into treatment.

While paranoia is the most typical manifestation, there are more types of delusion disorder including delusion of grandeur, delusional paranoid, even delusional jealousy as well as for example, believing one is the secret love interest of a famous person, being convinced one has striking abilities or is very significant, worrying about physical problems or disfigurements that do not exist, or believing that one's romantic partner is unfaithful. Psychological fitness treatment is sometimes refused because of these convictions, which are immune to any sort of disproof. The patient is certain they are correct.

Therapists who are ready to be used slightly different treatments, instead adopt the more usual drugs or characteristic psychotherapy approaches. They may gain the patient's trust enough to begin exploring any doubts the person expresses about their own ideology. The two of them can work in partnership, gradually discovering real world explanations for those ideology. If the therapist treads conscientiously and uses tactfully, then the patient and therapist together can work through the delusion disorder like delusion of grandeur, delusional paranoid, even delusional jealousy and effect a cure.

2.4.4 Motivated or Defensive Delusions

Some predisposed persons might suffer the onset of an ongoing delusional disorder when coping with life and maintaining high self esteem becomes a significant challenge. In order to preserve a positive view of oneself, a person views others as the cause of personal difficulties that may occur. This can then become an ingrained pattern of thought.

2.5 DELUSIONS AND OTHER DISORDERS

Even though the main characteristic of delusional disorder is a noticeable system of delusional beliefs, delusions may occur in the course of a large number of other psychiatric disorders.

Delusions are often observed in persons with other psychotic disorders such as schizophrenia and schizoaffective disorder. In addition to occurring in the psychotic disorders, delusions also may be evident as part of a response to physical, medical conditions (such as brain injury or brain tumors), or reactions to ingestion of a drug.

Delusions also occur in the dementias, which are syndromes wherein psychiatric symptoms and memory loss result from deterioration of brain tissue. Because delusions can be shown as part of many illnesses, the diagnosis of delusional disorder is partially conducted by process of elimination.

If the delusions are not accompanied by persistent, recurring hallucinations, then schizophrenia and schizoaffective disorder are not appropriate diagnoses. If the delusions are not accompanied by memory loss, then dementia is ruled out.

If there is no physical illness or injury or other active biological cause (such as drug ingestion or drug withdrawal), then the delusions cannot be attributed to a general medical problem or drug-related causes. If delusions are the most obvious and pervasive symptom, without hallucinations, medical causation, drug influences or memory loss, then delusional disorder is the most appropriate categorisation.

Because delusions occur in many different disorders, some clinician researchers have argued that there is little usefulness in focusing on what diagnosis the person has been given.

Those who ascribe to this view believe it is more important to focus on the symptom of delusional thinking, and find ways to have an effect on delusions, whether they occur in delusional disorder or schizophrenia or schizoaffective disorder.

The majority of psychotherapy techniques used in delusional disorder come from symptom-focused (as opposed to diagnosis-focused) researcher-practitioners.

Self Assessment Questions

1) What is Delusional Disorder? Define and bring out its characteristic features.

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2) What are delusions of grandeur?

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3) Describe delusions of persecution and erotomania.

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4) What are motivated defensive delusions?

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5) Discuss delusions as part of other psychiatric disorders.

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2.6 TREATMENT APPROACHES TO PARANOIA AND DELUSIONAL DISORDER

A cure of paranoia is very difficult and it is essential that treatment should be started immediately the disease comes to be known. Once it grows on a person there is no curing to it. The chief method of curing it is the following:

2.6.1 Treatment and Cure

A cure of paranoia is very difficult and it is essential that treatment should be started immediately the disease comes to be known. Once it grows on a person there is no curing to it. The chief method of curing it is the administering Injection of Insulin. Some patients also responds to this treatment but this cannot be said of all.

2.6.2 Psychoanalytic Method

Compared to other mental diseases, this disease does not respond immediately to psychoanalytic treatment because, being suspicious, the patient does not cooperate with the doctor. Even then, with due precaution, certain results can be achieved by employing this method.

2.6.3 Cognitive Behavioural Therapy (CBT)

CBT or other forms of psychotherapy may be helpful for certain people who have paranoia. CBT attempts to make a person more aware of his or her actions and motivations, and tries to help the individual learn to more accurately interpret cues around him or her, in an effort to help the individual change dysfunctional behaviours. Difficulty can enter into a therapeutic relationship with a paranoid individual, due to the level of mistrust and suspicion that is likely to interfere with their ability to participate in this form of treatment.

Support groups can be helpful for some paranoid individuals—particularly helpful in assisting family members and friends who must learn to live with, and care for paranoid individuals.

2.6.4 Drug Therapy

Treatment with appropriate antipsychotic drugs may help the paranoid patient overcome some symptoms. Although the patient's functioning may be improved, the paranoid symptoms often remain intact. Some studies indicate that symptoms improve following drug treatment, but the same results sometimes occur among patients who receive a placebo, a "sugar pill" without active ingredients. This finding suggests that in some cases the paranoia diminishes for psychological reasons rather than because of the drug's action.

Delusional disorder treatment often involves *atypical* (also called *novel* or *newer-generation*) antipsychotic medications, which can be effective in some patients. Risperidone (Risperdal), quetiapine (Seroquel), and olanzapine (Zyprexa) are all examples of atypical or novel antipsychotic medications.

If *agitation* occurs, a number of different antipsychotics can be used to conclude the outbreak of acute agitation. Agitation, a state of frantic activity experienced concurrently with anger or exaggerated fearfulness, increases the risk that the client will endanger self or others.

To decrease anxiety and slow behaviour in emergency situations where agitation is a factor, an injection of haloperidol (Haldol) is often given usually in combination with other medications (often lorazepam , also known as Ativan).

Agitation in delusional disorder is a typical response to severe or harsh confrontation when dealing with the existence of the delusions. It can also be a result of blocking the individual from performing inappropriate actions the client views as urgent in light of the delusional reality.

A novel antipsychotic is generally given orally on a daily basis for ongoing treatment meant for long-term effect on the symptoms.

Response to antipsychotics in delusional disorder seems to follow the "rule of thirds," in which about one-third of patients respond somewhat positively, one-third show little change, and one-third worsen or are unable to comply.

Cognitive therapy has shown promise as an emerging treatment for delusions. The cognitive therapist tries to capitalise on any doubt the individual has about the delusions; then attempts to develop a joint effort with the sufferer to generate alternative explanations, assisting the client in checking the evidence. This examination proceeds in favour of the various explanations.

Much of the work is done by use of empathy, asking hypothetical questions in a form of therapeutic Socratic dialogue—a process that follows a basic question and answer format, figuring out what is known and unknown before reaching a logical conclusion.

2.6.5 Combining Pharmacotherapy with Cognitive Therapy

The integration of both the treatment may being out the possible underlying biological problems and the symptoms can be reduced with psychotherapy.

2.6.6 Psychotherapy

This is the primary treatment for delusional disorder, including psychosocial treatment which can help with the behavioural and psychological problems associated with delusional disorder. Through therapy, patients also can learn to control their symptoms,

identify early warning signs of relapse, and develop a relapse prevention plan. Psychosocial therapies include the following:

Individual psychotherapy: Can help the person recognise and correct the underlying thinking that has become distorted.

Cognitive behavioural therapy (CBT): Can help the person learn to recognise and change thought patterns and behaviours that lead to troublesome feelings.

Family therapy: Can help families deal more effectively with a loved one who has delusional disorder, enabling them to contribute to a better outcome for the person.

2.6.7 Prognosis of Paranoia and Delusional Disorder

Predicting the prognosis of an individual suffering from Paranoia is quite difficult. Paranoia generally becomes a whole life or lifelong condition if there exists any underlying mental disorder, such as schizophrenia or paranoid personality disorder. It certainly and sometimes get better with some treatments or remission or with slight changes in medication. People who have symptoms of paranoia as part of another medical condition may also have a waxing and waning mental course.

Sometimes it is the case that paranoia is caused by the use of a particular drug or medication. In this case, it is possible that discontinuing that substance may completely reverse the symptoms of paranoia.

Paranoia can also occur as a symptom of other neurological diseases. Individuals suffering from the aftereffects of strokes, brain injuries, various types of **dementia** (including Alzheimer's disease), Huntington's disease, and Parkinson's disease may manifest paranoia as part of their symptom complex. The paranoia may decrease in intensity when the underlying disease is effectively treated, although since many of these diseases are progressive, the paranoia may worsen over time along with the progression of the disease's other symptoms.

2.7 LET US SUM UP

We defined paranoia as a medical illness, which happens to affect the brain, and causes changes in thinking and feeling. Those with the condition are hypersensitive, are easily slighted, and habitually relate to the world by vigilant scanning of the environment for clues or suggestions to validate their prejudicial ideas or biases.

Paranoid individuals are eager observers. They think they are in danger and look for signs and threats of that danger, disregarding any facts. They tend to be guarded and suspicious and have quite constricted emotional lives. Their incapacity for meaningful emotional involvement and the general pattern of isolated withdrawal often lend a quality of schizoid isolation to their life experience.

Even at the present time, a delusion need not be suspicious or fearful to be classified as paranoid. A person might be diagnosed as a paranoid schizophrenic without delusions of persecution, simply because their delusions refer mainly to themselves.

Their fear, and the threats they perceive in the innocent statements and actions of others, often contributes to frequent complaining or unfriendly withdrawal or aloofness. They can be confrontational, aggressive and disputatious. It is not unusual for them to sue people they feel have wronged them. The main symptom of paranoia is permanent delusion. It should be kept in mind that there is delusion in schizophrenia also but in that case it is not permanent or organised. In paranoia the symptoms of delusion appear gradually, and the patient is sentimental, suspicious, irritable, introverted, depressed,

obstinate, jealous, selfish, unsocial and bitter. Hence his social and family adjustment is not desirable, and while he has the highest desirable, the effort that he is prepared to expend is correspondingly little.

The "Diagnostic and Statistical Manual of Mental Disorders", fourth edition (DSM-IV), has listed the symptoms of paranoid personality disorder:

Then we deal with different kinds of paranoia such as the persecutory, religious, reformatory, erotic, litigious etc. Then the causes of paranoia were delineated.

Delusions are often observed in persons with other psychotic disorders such as schizophrenia and schizoaffective disorder. In addition to occurring in the psychotic disorders, delusions also may be evident as part of a response to physical, medical conditions (such as brain injury or brain tumors), or reactions to ingestion of a drug.

Delusions also occur in the dementias, which are syndromes wherein psychiatric symptoms and memory loss result from deterioration of brain tissue. Because delusions can be shown as part of many illnesses, the diagnosis of delusional disorder is partially conducted by process of elimination.

The majority of psychotherapy techniques used in delusional disorder come from symptom-focused (as opposed to diagnosis-focused) researcher-practitioners. A cure of paranoia is very difficult and it is essential that treatment should be started immediately the disease comes to be known. Once it grows on a person there is no curing to it. The chief method of curing it is the following:

Compared to other mental diseases, this disease does not respond immediately to psychoanalytic treatment because, being suspicious, the patient does not cooperate with the doctor. Even then, with due precaution, certain results can be achieved by employing this method.

CBT or other forms of psychotherapy may be helpful for certain people who have paranoia. CBT attempts to make a person more aware of his or her actions and motivations, and tries to help the individual learn to more accurately interpret cues around him or her, in an effort to help the individual change dysfunctional behaviours. Difficulty can enter into a therapeutic relationship with a paranoid individual, due to the level of mistrust and suspicion that is likely to interfere with their ability to participate in this form of treatment.

Delusional disorder treatment often involves *atypical* (also called *novel* or *newer-generation*) antipsychotic medications, which can be effective in some patients. Risperidone (Risperdal), quetiapine (Seroquel), and olanzapine (Zyprexa) are all examples of atypical or novel antipsychotic medications.

Predicting the prognosis of an individual suffering from Paranoia is quite difficult. Paranoia generally becomes a whole life or lifelong condition if there exists any underlying mental disorder, such as schizophrenia or paranoid personality disorder. It certainly and sometimes get better with some treatments or remission or with slight changes in medication. People who have symptoms of paranoia as part of another medical condition may also have a waxing and waning mental course.

2.8 UNIT END QUESTIONS

1) Define paranoia and delineate its characteristic features.
2) What are the symptoms of paranoi and what are its causes?
3) What are delusional disorders?
4) Describe in detail the delusional disorder of grandeur and persecution

5) What are motivated delusions?

6) What are the various treatment methods available for paranoia and delusional disorders? How effective they are?

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