PARANOID IDEATION

BEHAVIORAL DEFINITIONS

1. Extreme or consistent distrust of others generally or someone specifically, without sufficient basis.
2. Expectation of being exploited or harmed by others.
3. Misinterpretation of benign events as having threatening personal significance.
4. Hypersensitivity to hints of personal critical judgment by others.
5. Inclination to keep distance from others out of fear of being hurt or taken advantage of.
6. Tendency to be easily offended and quick to anger; defensiveness is common.
7. A pattern of being suspicious of the loyalty or fidelity of spouse or significant other without reason.
8. Level of mistrust is obsessional to the point of disrupting daily functioning.

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LONG-TERM GOALS

1. Show more trust in others by speaking positively of them and reporting comfort in socializing.
2. Interact with others without defensiveness or anger.
3. Verbalize trust of significant other and eliminate accusations of disloyalty.

4. Report reduced vigilance and suspicion around others as well as more relaxed, trusting, and open interaction.
5. Concentrate on important matters without interference from suspicious obsessions.
6. Function appropriately at work, in social activities, and in the community with only minimal interference from distrustful obsessions.

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SHORT-TERM OBJECTIVES

1. Demonstrate a level of trust with therapist by disclosing feelings and beliefs. (1, 2)

2. Identify those people or agencies that are distrusted and why. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Actively build level of trust with the client by explicitly acknowledging the client's difficulty, allowing him/her to lead discussions and establishing one's role as the therapist, whose interest in the client is strictly professional.
2. Use good eye contact, active listening, unconditional positive regard, and warm acceptance to help increase the client's ability to identify and express feelings; demonstrate a calm, tolerant demeanor in sessions to decrease the client's fears.
3. Assess the nature, extent, and severity of the client's paranoia, probing for delusional beliefs and conviction in them.
4. Explore the client's basis for fears; assess his/her degree of irrationality and ability to acknowledge that he/she is thinking irrationally.

3. Complete a psychological evaluation to assess the depth of paranoia. (5)

4. Disclose any history of substance use that may contribute to and complicate the treatment of paranoid ideation. (6)

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)

5. Refer or conduct psychological and/or neuropsychological testing including assessment of a possible psychotic process (e.g., Minnesota Multiphasic Personality Inventory-2, NEO Personality Inventory-Revised, The Schedule for Nonadaptive and Adaptive Personality-2, give relevant feedback of results to the client.

6. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and

	factors that could offer a better understanding of the client's behavior.
	10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
6. Comply with a medical evaluation to assess medical health. (11)	11. Refer the client to a physician for a medical evaluation to rule out a possible medical and/or substance-related etiology.
7. Comply with a psychiatric evaluation and take psychotropic medication as prescribed. (12, 13, 14)	12. Assess the necessity for anti-psychotic medication and the client's willingness to explore the option.
	13. Refer the client to a psychiatrist for a medication evaluation to assess the need for a psychotropic medication prescription.
	14. Monitor the client's psychotropic medication prescription for compliance, effectiveness, and side effects; report to the prescribing physician and directly address noncompliance, if present.
8. Participate in a comprehensive rehabilitation program for the presenting problem. (15)	15. Assess whether the client's paranoid ideation is occurring within a clinical syndrome (e.g., paranoid schizophrenia, delusional disorders), and if so, conduct or refer to an appropriate evidence-based treatment that is delivered as part of

a comprehensive rehabilitation program (e.g., see the Psychoticism chapter in this *Planner*).

9. Identify feelings associated with the distrust. (16, 17, 18)

16. Probe feelings that may underlie paranoia including inferiority, shame, humiliation, rejection.

17. Explore historical sources of the client's feelings of vulnerability in family-of-origin experiences.

18. Interpret the client's paranoia as a defense against his/her expressed feelings including inferiority, shame, humiliation, rejection.

10. Identify core belief that others are untrustworthy and malicious. (19, 20)

19. Explore the client's self-talk and maladaptive beliefs that underlie paranoia (e.g., people cannot be trusted, getting close to people will result in hurt).

20. Review the client's social interactions to explore his/her distorted cognitive beliefs operative during interactions.

11. Explore the positive and negative impact of beliefs that others are untrustworthy and malicious. (21)

21. Facilitate a cost-benefit analysis around the client's specific fears; or assign the client to complete a cost-benefit analysis exercise (see *The Feeling Good Handbook* by Burns); process the results toward continuing movement toward therapeutic goals.

12. Acknowledge other feelings that may underlie distrust of others. (22, 23)

22. Assess for the client's ability to acknowledge that his/her thinking is maladaptive; work to improve acknowledgement.

23. Assist the client in seeing the pattern of distrusting others as being related to his/her own fears of inadequacy.

13. Acknowledge that the belief about others being threatening is based more on subjective

24. Assist the client in generating alternatives to distorted thoughts and beliefs that correct for the

interpretation than on objective data. (24, 25)

biases; use role reversal to allow the client to argue for and against biased and alternative beliefs toward facilitating cognitive restructuring.

25. Assign the client to test distorted and alternative beliefs through behavioral experiments in which both are converted to predictions and tested through homework exercises.

14. Verbalize trust in significant other and feel relaxed when not in his/her presence. (26, 27)

26. Conduct conjoint sessions to assess and reinforce the client's verbalizations of trust toward significant other.

27. Provide alternative explanations for significant other's behavior that counters the client's pattern of assumption of other's malicious intent.

15. Learn and implement skills that facilitate increased satisfying social interaction without fear or suspicion. (28, 29)

28. Encourage the client not to jump to conclusions about others but rather check out his/her beliefs regarding others by respectfully and assertively verifying conclusions with others.

29. Use instruction, role-playing, behavioral rehearsal, and role reversal to increase the client's empathy for others, his/her understanding of the impact that his/her distrustful defensive behavior has on others, and develop effective relevant social skills.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.23	Social Phobia
	310.1	Personality Change Due to Axis III Disorder
	295.30	Schizophrenia, Paranoid Type
	297.1	Delusional Disorder
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Axis II:	301.0	Paranoid Personality Disorder
	310.22	Schizotypal Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.23	F40.10	Social Anxiety Disorder (Social Phobia)
310.1	F07.0	Personality Change Due to Another Medical Condition
295.30	F20.9	Schizophrenia
298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
297.1	F22	Delusional Disorder
298.8	F23	Brief Psychotic Disorder
295.4	F20.40	Schizophreniform Disorder
301.0	F60.0	Paranoid Personality Disorder
310.22	F21	Schizotypal Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.