The Paranoid Patient: Perils and Pitfalls

Phillip J. Resnick, MD
Professor of Psychiatry
Case Western Reserve University
Director of Forensic Psychiatry
University Hospitals Case Medical Center
Cleveland, Ohio

Did the psychiatrist fall below the standard of care by allowing the steelworker to go home?
Teaching Points

- A building crescendo of paranoid fear creates a high risk of violence
- A clinician should not surrender professional judgment to family
- Posing a threat is different from making a threat

Psychosis and Homicide

The rate of homicide during first-episode psychosis is 15 times greater than the annual rate after treatment.

First-Episode Psychosis

- One-third of patients commit violence before receiving treatment
- The longer the symptoms are untreated, the more the serious violence

Overview

- Delusions and violence
- Paranoia and violence
- Motives for paranoid violence
- Paranoid safety behaviors
- Evaluation of violence risk

Psychosis and Violence

Violent Behavior in the Last Year

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>%</th>
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<tbody>
<tr>
<td>No disorder</td>
<td>2</td>
</tr>
<tr>
<td>Major depression</td>
<td>12</td>
</tr>
<tr>
<td>Mania or bipolar disorder</td>
<td>11</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>13</td>
</tr>
<tr>
<td>Alcohol abuse or dependence</td>
<td>25</td>
</tr>
<tr>
<td>Other drug abuse or dependence</td>
<td>35</td>
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Thomas Theorem

If people define situations as real, they are real in their consequences.

Dangerous Delusions

- Erotomania
- Misidentification
- Threat/Control-Override
- Persecutory

Erotomania

- A delusional belief that one is loved
- It is usually toward a person of higher status
- Violence risk to love object and person seen standing in the way

Misidentification Delusions

- Capgras syndrome
- Persons replaced by imposters
- Threat by imposter → violence

SMI = serious mental illness.


Threat and Control-Override Symptoms

- Mind feels dominated by external forces
- Thoughts are being put into head
- Feeling that people wish you harm

Non-Violent Delusions

- Feeling dead or not existing
- Thoughts are broadcast
- Thoughts are removed

Alexis

Paranoid Delusions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Schizophrenia</td>
<td>50%</td>
</tr>
<tr>
<td>Psychotic depression</td>
<td>44%</td>
</tr>
<tr>
<td>Dementia</td>
<td>31%</td>
</tr>
<tr>
<td>Mania</td>
<td>28%</td>
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Threat Anticipation Model of Paranoia

- Patient attempts to make sense of odd feelings
- Patient interprets ambiguous experiences negatively
- Anxiety concerns about the anticipation of threats
- Ideas become persecutory when attribute intention to perpetrators

Paranoid Persons

- 20 times more likely to have a history of receiving threats
- Excessive sensitivity to others’ negative emotions
- Attend selectively to threat stimuli

Paranoid Delusions

- Most dangerous
- Well planned violence
- Usually preemptive strike
- Occasionally vengeance

Gender Response to Threats

- Men respond with violence
  - “Fight or flight”
  - Become aggressive
- Women respond without violence
  - “Tend and befriend”
  - Seek nurturing relationships

Increased Violence in Paranoid Delusions

- Systematized delusions
- Anxiety and distress
- Anger and fear

Paranoid Violence

- Occurs when there is a high degree of perceived threat
- Mediated by anger
- Severe dysfunction impedes violence

Delusions, Violence, and Anger

- Delusions of persecution
- Delusions of conspiracy
- Delusions of being spied on
Paranoid Violence Motives

- Self-defense
- Defense of manhood
- Defense of children
- Defense of the world

Paranoia Formulation

I love you.
I hate you.
You hate me.


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Responses to Paranoid Fear
Safety Behaviors

- Avoidance
- Protection
- Decrease visibility
- Enhance vigilance

Evidence of Paranoid Fear

- Changes of residence
- Long trips to evade persecutors
- Barricading their rooms
- Carrying weapons for protection
- Asking police for protection

Evaluation of the Paranoid Patient for Risk of Violence

- Therapeutic alliance
- Hear full paranoid story
- Maintain some distance
- Be nonjudgmental

Assaults Against Residents

- Psychiatry: 54%
- Surgery: 38%
- Internal medicine: 28%
- Emergency medicine: 26%
- Pediatrics: 7%

Violence Risk Assessment

- Confront with persecutor
- Perceived intentionality
- Substance abuse
- Weapons available
Stimulants and Violence

- Disinhibition
- Grandiosity
- Paranoia


Violence Prevention Plan

<table>
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<tr>
<th>Risk Factor</th>
<th>Management/Treatment</th>
<th>Status</th>
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Evaluation of Risk after Paranoid Violence

- Prodromal symptoms
- Warning behaviors
- Quickness of onset

Hodgins S. Arch Gen Psychiatry. 1992;49(6):476-483.

Timing of Violence

The median length of time between the onset of an acute psychotic episode and violence is 30 days.

Summary

- Paranoia can lead to severe violence
- Assess how the patient is responding to paranoia
- Threats may or may not precede paranoid violence