proach is to describe more specific areas of personality dysfunction, including as many as 15–40 dimensions (e.g., affective reactivity, social apprehensiveness, cognitive distortion, impulsivity, insincerity, self-centeredness). Other dimensional models that have been proposed include positive affectivity, negative affectivity, and constraint; novelty seeking, reward dependence, harm avoidance, persistence, self-directedness, cooperativeness, and self-transcendence; power (dominance vs. submission) and affiliation (love vs. hate); and pleasure seeking versus pain avoidance, passive accommodation versus active modification, and self-propagation versus other nurturance. The DSM-IV Personality Disorder clusters (i.e., odd-eccentric, dramatic-emotional, and anxious-fearful) may also be viewed as dimensions representing spectra of personality dysfunction on a continuum with Axis I mental disorders. The alternative dimensional models share much in common and together appear to cover the important areas of personality dysfunction. Their integration, clinical utility, and relationship with the Personality Disorder diagnostic categories and various aspects of personality dysfunction are under active investigation.

Cluster A Personality Disorders

301.0 Paranoid Personality Disorder

Diagnostic Features

The essential feature of Paranoid Personality Disorder is a pattern of pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with this disorder assume that other people will exploit, harm, or deceive them, even if no evidence exists to support this expectation (Criterion A1). They suspect on the basis of little or no evidence that others are plotting against them and may attack them suddenly, at any time and without reason. They often feel that they have been deeply and irreversibly injured by another person or persons even when there is no objective evidence for this. They are preoccupied with unjustified doubts about the loyalty or trustworthiness of their friends and associates, whose actions are minutely scrutinized for evidence of hostile intentions (Criterion A2). Any perceived deviation from trustworthiness or loyalty serves to support their underlying assumptions. They are so amazed when a friend or associate shows loyalty that they cannot trust or believe it. It they get into trouble, they expect that friends and associates will either attack or ignore them.

Individuals with this disorder are reluctant to confide in or become close to others because they fear that the information they share will be used against them (Criterion A3). They may refuse to answer personal questions, saying that the information is "nobody's business." They read hidden meanings that are demeaning and threatening into benign remarks or events (Criterion A4). For example, an individual with this disorder may misinterpret an honest mistake by a store clerk as a deliberate attempt to shortchange or may view a casual humorous remark by a co-worker as a serious

character attack. Compliments are often misinterpreted (e.g., a compliment on a new acquisition is misinterpreted as a criticism for selfishness; a compliment on an accomplishment is misinterpreted as an attempt to coerce more and better performance). They may view an offer of help as a criticism that they are not doing well enough on their own.

Individuals with this disorder persistently bear grudges and are unwilling to forgive the insults, injuries, or slights that they think they have received (Criterion A5). Minor slights arouse major hostility, and the hostile feelings persist for a long time. Because they are constantly vigilant to the harmful intentions of others, they very often feel that their character or reputation has been attacked or that they have been slighted in some other way. They are quick to counterattack and react with anger to perceived insults (Criterion A6). Individuals with this disorder may be pathologically jealous, often suspecting that their spouse or sexual partner is unfaithful without any adequate justification (Criterion A7). They may gather trivial and circumstantial "evidence" to support their jealous beliefs. They want to maintain complete control of intimate relationships to avoid being betrayed and may constantly question and challenge the whereabouts, actions, intentions, and fidelity of their spouse or partner.

Paranoid Personality Disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder or if it is due to the direct physiological effects of a neurological (e.g., temporal lobe epilepsy) or other general medical condition (Criterion B).

Associated Features and Disorders

Individuals with Paranoid Personality Disorder are generally difficult to get along with and often have problems with close relationships. Their excessive suspiciousness and hostility may be expressed in overt argumentativeness, in recurrent complaining, or by quiet, apparently hostile aloofness. Because they are hypervigilant for potential threats, they may act in a guarded, secretive, or devious manner and appear to be "cold" and lacking in tender feelings. Although they may appear to be objective, rational, and unemotional, they more often display a labile range of affect, with hostile, stubborn, and sarcastic expressions predominating. Their combative and suspicious nature may elicit a hostile response in others, which then serves to confirm their original expectations.

Because individuals with Paranoid Personality Disorder lack trust in others, they have an excessive need to be self-sufficient and a strong sense of autonomy. They also need to have a high degree of control over those around them. They are often rigid, critical of others, and unable to collaborate, although they have great difficulty accepting criticism themselves. They may blame others for their own shortcomings. Because of their quickness to counterattack in response to the threats they perceive around them, they may be litigious and frequently become involved in legal disputes. Individuals with this disorder seek to confirm their preconceived negative notions regarding people or situations they encounter, attributing malevolent motivations to others that are projections of their own fears. They may exhibit thinly hidden, unrealistic grandiose fantasies, are often attuned to issues of power and rank, and tend to develop negative stereotypes of others, particularly those from population groups

distinct from their own. Attracted by simplistic formulations of the world, they are often wary of ambiguous situations. They may be perceived as "fanatics" and form tightly knit "cults" or groups with others who share their paranoid belief systems.

Particularly in response to stress, individuals with this disorder may experience very brief psychotic episodes (lasting minutes to hours). In some instances, Paranoid Personality Disorder may appear as the premorbid antecedent of Delusional Disorder or Schizophrenia. Individuals with this disorder may develop Major Depressive Disorder and may be at increased risk for Agoraphobia and Obsessive-Compulsive Disorder. Alcohol and other Substance Abuse or Dependence frequently occur. The most common co-occurring Personality Disorders appear to be Schizotypal, Schizoid, Narcissistic, Avoidant, and Borderline.

Specific Culture, Age, and Gender Features

Some behaviors that are influenced by sociocultural contexts or specific life circumstances may be erroneously labeled paranoid and may even be reinforced by the process of clinical evaluation. Members of minority groups, immigrants, political and economic refugees, or individuals of different ethnic backgrounds may display guarded or defensive behaviors due to unfamiliarity (e.g., language barriers or lack of knowledge of rules and regulations) or in response to the perceived neglect or indifference of the majority society. These behaviors can, in turn, generate anger and frustration in those who deal with these individuals, thus setting up a vicious cycle of mutual mistrust, which should not be confused with Paranoid Personality Disorder. Some ethnic groups also display culturally related behaviors that can be misinterpreted as paranoid.

Paranoid Personality Disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, social anxiety, underachievement in school, hypersensitivity, peculiar thoughts and language, and idiosyncratic fantasies. These children may appear to be "odd" or "eccentric" and attract teasing. In clinical samples, this disorder appears to be more commonly diagnosed in males.

Prevalence

The prevalence of Paranoid Personality Disorder has been reported to be 0.5%–2.5% in the general population, 10%–30% among those in inpatient psychiatric settings, and 2%–10% among those in outpatient mental health clinics.

Familial Pattern

There is some evidence for an increased prevalence of Paranoid Personality Disorder in relatives of probands with chronic Schizophrenia and for a more specific familial relationship with Delusional Disorder, Persecutory Type.

Differential Diagnosis

Paranoid Personality Disorder can be distinguished from **Delusional Disorder, Persecutory Type, Schizophrenia, Paranoid Type,** and **Mood Disorder With Psychotic Features** because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). To give an additional diagnosis of Paranoid Personality Disorder, the Personality Disorder must have been present before the onset of psychotic symptoms and must persist when the psychotic symptoms are in remission. When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophrenia) that was preceded by Paranoid Personality Disorder, Paranoid Personality Disorder should be recorded on Axis II, followed by "Premorbid" in parentheses.

Paranoid Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified). Finally, it must also be distinguished from **paranoid traits associated with the development of physical handicaps** (e.g., a hearing impairment).

Other Personality Disorders may be confused with Paranoid Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Paranoid Personality Disorder, all can be diagnosed. Paranoid Personality Disorder and **Schizotypal Personality Disorder** share the traits of suspiciousness, interpersonal aloofness, and paranoid ideation, but Schizotypal Personality Disorder also includes symptoms such as magical thinking, unusual perceptual experiences, and odd thinking and speech. Individuals with behaviors that meet criteria for **Schizoid Personality Disorder** are often perceived as strange, eccentric, cold, and aloof, but they do not usually have prominent paranoid ideation. The tendency of individuals with Paranoid Personality Disorder to react to minor stimuli with anger is also seen in **Borderline** and **Histrionic Personality Disorders.** However, these disorders are not necessarily associated with pervasive suspiciousness. People with **Avoidant Personality Disorder** may also be reluctant to confide in others, but more because of a fear of being embarrassed or found inadequate than from fear of others' malicious intent. Although antisocial behavior may be present in some individuals with Paranoid Personality Disorder, it is not usually motivated by a desire for personal gain or to exploit others as in **Antisocial Personality Disorder,** but rather is more often due to a desire for revenge. Individuals with **Narcissistic Personality Disorder** may occasionally display suspiciousness, social withdrawal, or alienation, but this derives primarily from fears of having their imperfections or flaws revealed.

Paranoid traits may be adaptive, particularly in threatening environments. Paranoid Personality Disorder should be diagnosed only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress.

Diagnostic criteria for 301.0 Paranoid Personality Disorder

A. 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:

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

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)."

301.20 Schizoid Personality Disorder

Diagnostic Features

The essential feature of Schizoid Personality Disorder is a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with Schizoid Personality Disorder appear to lack a desire for intimacy, seem indifferent to opportunities to develop close relationships, and do not seem to derive much satisfaction from being part of a family or other social group (Criterion A1). They prefer spending time by themselves, rather than being with other people. They often appear to be socially isolated or "loners" and almost always choose solitary activities or hobbies that do not include interaction with others (Criterion A2). They prefer mechanical or abstract tasks, such as computer or mathematical games. They may have very little interest in having sexual experiences with another person (Criterion A3) and take pleasure in few, if any, activities (Criterion A4). There is usually a reduced experience of pleasure from sensory, bodily, or interpersonal experiences, such as walking on a beach at sunset or having sex. These individuals have

no close friends or confidants, except possibly a first-degree relative (Criterion A5).

Individuals with Schizoid Personality Disorder often seem indifferent to the approval or criticism of others and do not appear to be bothered by what others may think of them (Criterion A6). They may be oblivious to the normal subtleties of social interaction and often do not respond appropriately to social cues so that they seem socially inept or superficial and self-absorbed. They usually display a "bland" exterior without visible emotional reactivity and rarely reciprocate gestures or facial expressions, such as smiles or nods (Criterion A7). They claim that they rarely experience strong emotions such as anger and joy. They often display a constricted affect and appear cold and aloof. However, in those very unusual circumstances in which these individuals become at least temporarily comfortable in revealing themselves, they may acknowledge having painful feelings, particularly related to social interactions.

Schizoid Personality Disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder or if it is due to the direct physiological effects of a neurological (e.g., temporal lobe epilepsy) or other general medical condition (Criterion B).

Associated Features and Disorders

Individuals with Schizoid Personality Disorder may have particular difficulty expressing anger, even in response to direct provocation, which contributes to the impression that they lack emotion. Their lives sometimes seem directionless, and they may appear to "drift" in their goals. Such individuals often react passively to adverse circumstances and have difficulty responding appropriately to important life events. Because of their lack of social skills and lack of desire for sexual experiences, individuals with this disorder have few friendships, date infrequently, and often do not marry. Occupational functioning may be impaired, particularly if interpersonal involvement is required, but individuals with this disorder may do well when they work under conditions of social isolation. Particularly in response to stress, individuals with this disorder may experience very brief psychotic episodes (lasting minutes to hours). In some instances, Schizoid Personality Disorder may appear as the premorbid antecedent of Delusional Disorder or Schizophrenia. Individuals with this disorder may sometimes develop Major Depressive Disorder. Schizoid Personality Disorder most often co-occurs with Schizotypal, Paranoid, and Avoidant Personality Disorders.

Specific Culture, Age, and Gender Features

Individuals from a variety of cultural backgrounds sometimes exhibit defensive behaviors and interpersonal styles that may be erroneously labeled as schizoid. For example, those who have moved from rural to metropolitan environments may react with "emotional freezing" that may last for several months and be manifested by solitary activities, constricted affect, and other deficits in communication. Immigrants from other countries are sometimes mistakenly perceived as cold, hostile, or indifferent.