Spytska, L. V. (2025). Peculiarities of manifestation of paranoid delusions in the world. *Actual Issues of Modern Science. European Scientific e-Journal, 38*, 77–91. Ostrava.

DOI: 10.47451/psy2025-08-01

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Peculiarities of Manifestation of Paranoid Delusions in the World

Abstract: The relevance of the investigated problem lies in several debatable issues that the psychiatric community is trying to solve, one of which is the definition of clear clinical criteria for paranoid delusions. Long-term studies of disorders of thinking, perception, will, motor activity, which cause the formation of false conclusions about the surrounding world, today do not provide a comprehensive answer to the causes of the distorted consciousness of an individual. The purpose of the study is the diagnosis and research of the limits of the manifestation of paranoid delusions, which develops in the context of a personality disorder. The main method used to study the features of the manifestation of paranoid delusions was the clinical-psychopathic method. To conduct it, psychometric methods, psycho-diagnostic methods, as well as clinical and statistical methods of data processing were used as an auxiliary research tool. During this empirical study of the patient's personality, his intelligence, and cognitive abilities, it was possible to achieve results according to which the main criteria of a personality with manifestations of paranoid delusions were determined. Therefore, the main results of the study are the determination of the general regularity of the combination of mental and behavioural disorders, as a result of which a change in the clinical picture of the disease is observed. The general level of perception of the quality of life of patients with paranoid delusions was determined; a reasonably high level of suicidal risk; the reasons for the low level of social interaction in the professional and family spheres are revealed; identified determinants that increase depressive symptoms; the main behavioural strategies used by patients to interact with the surrounding people in the environment are presented. The practical significance of the materials of the article lies in the further successful correction of borderline states of mental illnesses in psychotherapy; in organizational psychiatric treatment; prevention and rehabilitation of mental pathologies.

Keywords: pathological condition, delusion, psychiatry, mental disorder, schizophrenia.

Abbreviations:

AAS is American Association of Suicidology,

$PANSS$ is Positive and Negative Syndrome Scale,

PPD is paranoid personality disorder,

$WHOQOL-SM$ is World Health Organization Quality of Life, special module.

Introduction

At the beginning of the 20th century, when psychiatry went beyond the boundaries of psychiatric hospitals, the modern stage of studying the borderline states of mental illnesses and psychotherapeutic forms of assistance to broad segments of the population began. According to the International Classification of Diseases 11th revision (ICD–11) (*2022*), paranoid delusion syndrome is a symptom of three mental disorders: schizophrenia of the paranoid type, delusional disorder, and paranoid personality disorder (PD). The following scientists studied the peculiarities of the manifestation of paranoid delusions—Kh. Zhyvaho (*2021*), S. Fedorchuk et al. (*2020*), O. Napreyenko (*2019*), M. Craske et al. (*2019*), M. Zimmerman (*2021*), J. Casarella (*2020*). O. Syropyatov et al. (*2021*)—the main cause of the pathogenesis of paranoid delusions is considered to be a malfunction of the central nervous system. According to them, the process of transmitting excitation and inhibition impulses is disrupted due to the underdevelopment of neurotransmitters. Brain cells are in an ultra-paradoxical phase. In such a phase, the image formed in the imagination does not correspond to reality.

Delusions and hallucinations are productive psychopathological symptoms that can be eliminated in therapy. However, A. Borozenets et al. (*2020*) prove that signs of paranoid delusions are very difficult to correct or cannot be corrected at all. A peculiar idea about the environment, contrary to the inconsistency with the surrounding reality, acquires the character of a special world-view. Attempts by people close to them to rationalize the falsity of their beliefs lead to isolation, limiting the patient's contacts, which can lead to a complex form of schizophrenia. S. Stavytska et al. (*2021*) call paranoid delusions autistic fantasizing—when it is difficult for patients to explain the nature of their inner experiences. This is due to the fact that the fundamental characteristic of this syndrome is thought disorders. S. Stavytska et al. describe in their works the results of a study in which patients with symptoms of paranoid delusions demonstrate disordered work of abstract thinking, disturbances in the work of logical thinking and rational cognition, which provoke a pathological interpretation of surrounding events. Objects and phenomena of the environment are displayed, their internal connections are distorted and perceived in this way. From the patient's point of view, such conclusions are always logically justified. Paranoid delusion is not systematic in nature, it is inconsistent, fragmentary, fantastic, often accompanied by emotional disorders, fear, confusion, anxiety. When delusional ideas acquire a more coherent system, paranoid occurs, and the inclusion of nonsensical, delusional ideas indicates the development of paraphrenia. Both signs are characteristics of severe forms of schizophrenia.

Paranoid schizophrenia is one of the most common diseases in which paranoid delusions develop. The etymology of schizophrenia, distinguishing only paranoid delusions, is characterized by stable delusional ideas of 1 month or more. During this period, delusions of persecution or its varieties are formed, and at the moment when the patient's legend finds its confirmation in the environment (purely based on his beliefs), "crystallization of delusions" occurs, a certain delusional system is built, which develops into the next stage. At this stage, delusions of grandeur appear. The inner world of such a person is impoverished, and to experience such a disconnection with one's own self, the psyche forms hallucinations in the form of a fantastic world and the special purpose of the individual in it. However, to establish a diagnosis of "schizophrenia", it is required to determine the presence of a complete list of clinical

symptoms according to the ICD-11 (*International Classification…, 2022*). Determining paranoid personality disorder as a separate psychiatric diagnosis is a primary task of psychiatry, because the indicators of some symptoms cannot be attributed to schizophrenia or any other type of psychopathy. There are transitional states that have been clinically confirmed in a group of schizoids with narcissistic and dissocial types of disorders, on the basis of which the basis of paranoid development and delusions emerges (*Deisenhammer et al., 2019*). The difficulty of establishing a diagnosis of paranoid personality disorder lies in the lack of a clear distinction between delusional ideas of other aetiology.

Therefore, the difficulties in identifying delusional symptoms form the relevance of the purpose of the study to identify the diagnostic minimum for the study of anomalies of personality disorders of people with paranoid delusions, which will serve to specify the diagnosis and speed up high-quality outpatient and therapeutic treatment.

Materials and Methods

During the research, the following theoretical research methods were applied: analysis, synthesis, concretization, generalization of scientific and methodological literature on psychology, psychiatry, philosophy. Among the diagnostic methods, the following psychometric methods were used: the PANSS (*Napreyenko, 2019*), the suicidal risk scale of the AAS (*Syropyatov et al., 2021*), a special module for patients with endogenous psychoses WHOQOL-SM (*Zhyvaho, 2021*); psychodiagnostic methods: method of diagnosing the level of social frustration of L.I. Wasserman in the modification of V.V. Boyko, individual-typological questionnaire L.N. Sobchyk (*Stavytska et al., 2021*); psychological observation and psychiatric interview. With the help of clinical and statistical methods, data processing was performed using the methods of descriptive statistics and graphical representation of the results.

An experimental psychological study of mentally ill patients was conducted using the clinical-psychopathological method in accordance with the tasks set in the article. So, the experiment was started with the formation of a sample, which was 421 schizophrenic patients aged 20 to 46 years. In most patients, the disease lasts from two years, a special requirement was the absence of diseases of the central nervous system, chronic diseases of the body. After collecting and studying the anamnesis of the patients, an experimental group was selected, which included 160 patients. Upon completion of the organizational measures, the diagnostic part of the experiment was immediately started. This stage took a long time. There was a lot of diagnostic material, and due to significant cognitive loads, patients quickly got tired. Therefore, it was very important to establish a trusting relationship with the patients, thus laying the groundwork for interaction with them in the research process. For this, a psychiatric interview was conducted with the respondents before starting the diagnosis. Through frank conversation, they tried to win the patient's trust in themselves, showing a desire to understand the patient through interest, sympathy, and empathy.

Analysing the anamnesis of the respondents during the psychiatric interview and carefully collected information from the control card of dispensary care for a patient with a mental disorder, it was found that the diagnosis of schizophrenia is combined with other mental disorders. Namely, depressive disorders (DD) (36 patients), chemical addictions and non-chemical addictions (35 and 33 patients, respectively), anxiety-phobic and obsessive-compulsive

disorders (OCD) (32 patients), as well as personality disorders (24). Diagnosis using psychometric and psychological methods continued throughout the year. During this time, 30 indicators of schizophrenia symptoms were studied with a gradation from 1 to 7 (where 1 is the absence of a symptom, 7 is its severity). PANSS (*Napreyenko, 2019*) has 3 subscales in total.

The suicidal risk scale of the American Association of Suicidology (*Syropyatov et al., 2021*) has 4 modules in which, according to a 5-point system (where 1 is the minimum level of symptom expression), the following were determined: the level of suicidal thoughts and their intensity, signs of suicidal behaviour, and the level of danger of suicidal attempts. Subjective assessment of the quality of life of mentally ill patients covers such areas of life as "positive/negative emotions and the ability to manage them", "cognitive functions", "ability to perform routine tasks", "ability to work", "personal relationships", the sphere of social interaction (rest, entertainment, relationships with loved ones and relatives), "orientation in oneself and the surrounding reality", "self-control". The maximum number of points according to the WHOQOL-SM (*Zhyvaho, 2021*) method can be 285 points (high level of quality of life), and 57—low level of quality of life. Examining patients using psychodiagnostic methods, the degree of dissatisfaction with social achievements in the main spheres of life was determined, where 5 is a high level of frustration, and 1 is low. Individual-typological characteristics, where the indicator of 9 points—expresses maladjustment of the individual. The main coping strategy was determined using 8 subscales.

Literature Review

The study of paranoid delusions as a complex psychopathological phenomenon has evolved through the integration of neurobiological, psychological, and social approaches. According to the International Classification of Diseases (*2022*), paranoid delusion syndrome may occur within the spectrum of schizophrenia, delusional disorder, or paranoid personality disorder, representing a multifactorial pathology that challenges precise diagnostic categorisation (*International Classification…, 2022*). Recent research underscores that while delusions and hallucinations are traditionally viewed as productive symptoms of psychosis, the stability and resistance of paranoid delusions to correction reveal their profound roots in both biological and experiential determinants (*Borozenets et al., 2020*; *Napreyenko, 2019*).

Scholars such as Zimmerman (*2021*) and Casarella (*2020*) emphasise that PPD is distinguished by deeply ingrained patterns of mistrust and suspicion that distort perception and cognition. This distortion results in an altered subjective reality, often accompanied by rigid defences against perceived threats. These cognitive biases are reinforced by emotional dysregulation, forming a persistent maladaptive schema that defines the paranoid worldview. Empirical studies confirm that individuals with PPD exhibit impaired insight and interpretive flexibility, which complicates differential diagnosis from schizophrenia spectrum disorders (*Zimmerman, 2021*).

From a neurobiological standpoint, researchers have explored the dysfunctions of neurotransmission and neuroendocrine regulation as critical in the formation of paranoid symptoms. Deisenhammer, Zetterberg, and Fitzner (*2019*) highlighted those disturbances in cerebrospinal fluid biomarkers in patients with schizophrenia and related psychoses reflect altered immune and neurochemical activity, influencing thought organisation. Complementing

this, Mikulska et al. (*2021*) proposed that the dysregulation of the hypothalamic–pituitary–adrenal axis contributes to chronic stress reactivity, exacerbating paranoid ideation. These biological models support the assumption that paranoia arises from an intersection of neurophysiological instability and cognitive overinterpretation of threat.

A significant body of literature also addresses the comorbidity between paranoid delusions and affective or addictive disorders. Studies by Fedorchuk et al. (*2020*) and Gannon et al. (*2019*) suggest that maladaptive coping mechanisms and physiological arousal may reinforce paranoid patterns, particularly among individuals with substance use histories or anxiety–depressive tendencies. This supports the biopsychosocial model, in which paranoia represents a defensive adaptation to chronic stress or trauma rather than a purely endogenous psychosis. Similarly, Craske, Meuret, and Ritz (*2019*) demonstrated that therapeutic modulation of affect and anxiety through positive affect treatments can reduce the intensity of delusional interpretations, showing the importance of emotional regulation in psychotherapeutic intervention.

Environmental and socio-economic determinants also play a substantial role in the development and persistence of paranoid delusions. Kalin (*2021*) and Mikulska et al. (*2021*) showed that urban density, economic hardship, and prolonged social stress correlate with a higher prevalence of delusional experiences. In urban environments, excessive sensory stimulation and social anonymity amplify cognitive distortions and hypervigilance (*Mikulska et al., 2021*). Epidemiological evidence indicates that paranoid delusions are equally frequent in developed and developing countries, yet the manifestations are more acute in populations exposed to extreme deprivation and instability (*Sall et al., 2019*).

From the perspective of developmental psychology, many authors trace paranoid formations to early experiences of mistrust and emotional neglect. Tibber, Kirkbride, and Mutsatsa (*2019*) identified socio-environmental factors such as familial dysfunction and bullying as precursors of paranoid traits in adolescence. Safai (*2022*) expanded this developmental typology by proposing five types of paranoid personalities—narcissistic, antisocial, compulsive, passive-aggressive, and decompensated—each of which reflects maladaptive responses to unmet childhood expectations and the internalisation of parental criticism. These findings suggest that early emotional deprivation and punitive upbringing form the psychological substrate for adult delusional ideation.

Further, studies by Hinojosa-Marqués et al. (*2021*) and Cosgrave, Purple, and Haines (*2021*) reveal the interpersonal mechanisms through which paranoia perpetuates itself. Using family-based and computational simulation methods, they demonstrated that individuals with paranoid delusions often externalise shame and blame, thereby provoking social rejection that confirms their negative expectations. This cyclical reinforcement of suspicion and isolation constitutes a key mechanism of chronicity. Paranoid cognition thus functions as a self-maintaining feedback system that converts interpersonal anxiety into delusional conviction.

The research of Zhyvaho (*2021*) and Stavytska et al. (*2021*) contributes to understanding the psychosocial dimensions of treatment and rehabilitation. Their studies show that low life satisfaction, frustration in family and social relations, and reduced emotional resilience are common among patients with paranoid delusions. Psychodiagnostic assessments using instruments such as WHOQOL-SM and the Wasserman–Boyko frustration scale indicate that these individuals experience pervasive deficits in social adaptation, often correlated with rigid

and introverted personality structures. Consequently, therapeutic strategies must focus not only on pharmacological correction but also on restoring patients' capacity for trust and social interaction.

In sum, the literature highlights paranoid delusions represent a multidimensional construct encompassing biological vulnerability, cognitive distortions, and social maladjustment. The convergence of findings from psychiatry, psychology, and neuroscience supports a unified view of paranoia as a complex adaptive failure shaped by both internal and environmental determinants (*Musliner et al., 2019*; *Pugle, 2021*). The integration of these perspectives forms the foundation for developing diagnostic frameworks capable of distinguishing paranoid personality disorder from schizophrenia and related psychoses, thereby enhancing treatment precision and clinical outcomes.

Results

In psychiatric practice, the presence of two independent diagnoses in a patient, which can be distinguished separately from each other, belongs to the category of comorbid diseases. Schizophrenia is sometimes combined with somatic diseases and mental disorders, which greatly complicates the effectiveness of treatment. In this study, 5 comorbidities were identified in the anamnesis of the patients' diseases that form a common symptom complex of schizophrenia or vice versa, become concomitant disorders in schizophrenia. After analysing the control cards of dispensary care for patients with mental disorders, the most common addictive disorders suffered by the patients were determined. The list of non-chemical means includes: tobacco, tea, coffee, alcohol, watching TV shows/series, computer games, food, and Internet abuse. There were rare cases of workaholism, gambling, and oniomania. Among psychoactive substances of chemical origin, opioids, psychostimulants, and sedatives prevailed. The article aims to determine which of the researched disorders has the most pronounced symptoms of paranoid delusions, and whether this syndrome can be separated into paranoid personality disorder. For this, a number of diagnostic techniques were conducted with the respondents, the results of which are given below (*Figure 1*).

It is known that persons with affective disorders, psychoses and those who abuse psychoactive substances have a fairly high level of suicidal risk. Suicidal thoughts are also characteristic of patients with schizophrenia, however, only patients with persecutory delusion resort to decisive actions. According to the results of diagnosis on the suicidal risk scale of the American Association of Suicidology (*Syropyatov et al., 2021*) managed to identify a group of patients with characteristic suicidal symptoms (*Figure 2*).

Therefore, according to the indicators presented in Figure 2, it can be concluded that the largest number of patients with a high tendency to suicide is a personality disorder. According to 4 modules of the suicidal risk scale of the American Association of Suicidology (*Syropyatov et al., 2021*), patients with this disorder have the highest indicators, especially according to the modules "suicidal behaviour" and "potential danger of suicidal attempts". Answers in these two scales can be given only by mentally ill patients who have had unsuccessful suicide attempts or typical preparatory measures.

With the help of a special module for patients with endogenous psychoses WHOQOL-SM (*Zhyvaho, 2021*), the level of perception of the quality of life by patients was investigated (*Figure*

3). Thanks to this psychometric technique, it was possible to determine the general level of subjective perception of the quality of life and the spheres affecting this indicator. The vast majority of patients have low indicators in the field of positive and negative emotions, which indicates difficulties in determining their emotional state in schizophrenia. The sphere of own functioning (cognitive capabilities, abilities to perform work and everyday tasks) also has low indicators. The spheres of recreation and entertainment, professional and family status, social interaction and support also have low indicators. High indicators could not be found in any sphere, which indicates the patients' dissatisfaction with the quality of their lives.

The results shown in Figure 3 confirm the data of the psycho-diagnostic examination according to the method of diagnosing the level of social frustration of L.I. Wasserman in the modification of V.V. Boyko (*Figure 4*) (*Stavytska et al., 2021*). Therefore, all respondents have an increased level of frustration: patients with a depressive disorder have frustrations in the field of "cognition" and "happy family life"; patients with schizophrenia who have compatible addictions showed a high level of frustration in the field of "material support of life"; patients with comorbid mental disorders in schizophrenia—obsessive-compulsive disorders have a high level of frustration in the areas of "freedom", "having friends", "happy family life"; schizophrenic patients with personality disorder have a high level of frustration in the sphere of "love", "having friends", "happy family life"; in patients with anxiety-phobic disorders, the spheres of "material support of life" and "happy family life" are frustrated. Therefore, it can be concluded that patients are dissatisfied with the quality of their lives due to the inability to establish relationships with people, which is why they lose the opportunity to create a family, have friends, and improve their financial situation.

The final method, which allowed creating the portrait of a person with a mental disorder of paranoid delusions, is the method of determining the typological features of the personality and leading character traits of L.M. Sobchyk (*Figure 5*) (*Stavytska et al., 2021*). With the help of this technique, the author was able to determine the leading trends in the development of the individual in the process of interaction of his "Me" with the social environment. So, according to Figure 5, it can be seen that some comorbid mental disorders in schizophrenia have maladaptive properties: in depressive disorder, these are "introversion" and "anxiety", that is, such patients are prone to isolation and alienation from the environment due to obsessive fears and panic reactions. In patients with addictive behaviour, "extraversion" is a maladaptive property. They have indecipherable social relationships, trying to solve their problems at the expense of other people. In patients with obsessive-compulsive disorder, "spontaneity", "sensitivity" and "anxiety" have maladaptive properties, that is, the neurotic state of such people consists in impulsive actions on which the patient spends all his resources.

Patients with schizophrenia and personality disorder showed maladaptive properties according to the parameters' "rigidity", "introversion", "anxiety" and "lability", that is, obsessive fears in combination with alienation form wariness and suspicion, in addition, the persistence of such people in their beliefs can lead to steroid manifestations. This means that personality disorder is the most widespread comorbid mental disorder in schizophrenia according to individual typological characteristics. Patients with anxiety-phobic disorders showed maladjustment in the properties of "introversion" and "anxiety". From the anamnesis, the patients were determined to have the following list of phobias: agoraphobia, specific isolated

phobias, generalized anxiety disorder, and social phobias. These phobias form their individual typological characteristics, which consist of obsessive fears and panic reactions, a tendency to isolation, and alienation from the environment.

Confirming the results obtained during the examination according to the individual-typological questionnaire L.N. Sobchyk (*Stavytska et al., 2021*), patients with comorbid mental disorders in schizophrenia choose a certain way of behaviour in a stressful situation to overcome difficulties (*Figure 6*).

Therefore, 70% of patients with a comorbid mental disorder in schizophrenia—depressive disorder has coping "taking responsibility". This coping is considered the most ecological way to solve the problem, however, in combination with the maladaptive character trait "anxiety", such people try to solve the problem to avoid punishment. Copings "escape-avoidance" and "planning" are characteristic of schizophrenia patients with addictions. This choice of coping is explained by the desire to "escape" from problems by choosing any type of addiction. And from the outside, such patients show a desire to get rid of a bad habit (they turn to a therapist, take medication), however, the negative symptoms of schizophrenia lead to new exacerbations. Only correct treatment of schizophrenia allows the patient to get rid of addictions. Patients with obsessive-compulsive disorder in schizophrenia have several coping strategies, the course of the disease burdened by the symptoms of schizophrenia requires efforts to regulate their feelings and actions, search for emotional support from the outside, solve problems to avoid punishment, plan their behaviour to control their actions and focusing on a positive assessment of the environment.

Patients with schizophrenia personality disorder choose to distance themselves from a stressful situation by making both behavioural and cognitive efforts. That is, the psyche of such people seeks to displace negative experiences, taking into account the maladaptive properties of the character (*Figure 5*). Such patients have an individual type of experience, which consists in creating their world-view, in which the patient shows his strengths and direction of motivation, style of relationships, and cognitive processes. Patients with anxiety-phobic disorders in schizophrenia, taking into account their individual and typological personality characteristics (*Figure 5*), resort to efforts to regulate their feelings and actions: they are in co-dependent relationships to receive emotional support; arbitrarily focused efforts to solve problems to avoid punishments; behavioural efforts aimed at escaping from problems.

Summarizing all of the above, it was possible to identify a comorbid mental disorder in schizophrenia, which, according to its symptoms and features of manifestation in the environment, has the aetiology of paranoid delusions, namely, personality disorder in schizophrenia. In the anamnesis of patients with comorbid personality disorders in schizophrenia, demonstrative and anxiety disorders prevailed; emotionally unstable and anankast—in smaller numbers. According to the symptoms, these disorders were divided into a separate group and a treatment protocol was applied to such patients, according to it the negative symptoms of schizophrenia are reduced. However, during the treatment, which was performed in a psychiatric clinic in outpatient conditions, the condition of the patients remained unchanged. The table (*Table 1*) summarizes all the symptoms of personality disorder in schizophrenia, which indicates the features of the manifestation of paranoid delusions.

So, in patients with paranoid delusions, such features of manifestation can be identified, which, with a complete symptom complex, can be distinguished as a personal mental disorder. It is noted that against the background of common symptoms that have been diagnosed in patients with other mental disorders in schizophrenia, the personality disorder is distinguished by such individual-typological features as rigidity and lability. The level of these properties beyond the norm is manifested in the inertia of judgments, wary suspicion, demonstrativeness and hysterical manifestations. That is, in the world-view of such a person, the entire environment is perceived as hostile, from which it is necessary to protect. Usually, such patients do not pose a threat to society, because there is no aggressiveness in their symptom complex. Suicide can be committed accidentally (in a state of affect, when it is difficult for the patient to control his emotions) or demonstrative suicide. The latter most often occurs against the background of delusions of persecution, when the patient harms himself to confirm his false ideas to convince others of the truth of his ideas.

Discussion

It is required to understand that at the basis of paranoid delusion lies psychological violence that occurred in childhood. Such events change the stereotype of thinking in the direction of negative judgments. Therefore, the symptoms of paranoid delusions are affected by both the personal characteristics of a person and the negative effects of the environment. From the research conducted in this article, it can be seen that two types of comorbid mental disorders in schizophrenia: obsessive-compulsive and anxiety-phobic have similar symptom complexes to personality disorder in schizophrenia, however, in the structure of these disorders, there are no such positive symptoms of schizophrenia as delusions, hallucinations, feelings own greatness, hostility and suspicion, as well as negative symptoms: disorders of abstract thinking. Paranoid delusions are also absent in comorbid psychiatric depressive disorders and various addictions in schizophrenia. Therefore, diagnosing the features of the manifestation of paranoid delusions causes certain difficulties, because in practical and scientific terms there are not enough diagnostic criteria for determining this mental illness. In modern studies of mental disorders of the personality, it was found that about 1–2% of patients have signs of paranoid delusions (*Sall et al., 2019*). Moreover, this indicator is the same both for developed countries and for the Third World countries. In a study by J. Gannon et al. (*Gannon, et al., 2019*) in European countries, 1 patient with paranoid delusions was found out of 1000 respondents, as well as in African and Asian countries. The only difference is that the pathogenesis of the disease in the Third World countries develops faster and manifests itself in acute states of confused consciousness.

The socio-economic factor affects the spread of paranoid delusions among low-income segments of the USA population. The author of this study, N. Kalin (*2021*), explains the high level of stress experienced by people from disadvantaged regions. The incidence of paranoid delusions increases in direct proportion to the number of the city's population. J. Mikulska et al. (*2021*) conducted a study in British cities with a population of over 100,000 people and found that cities with crowded streets, public transport and leisure facilities make some individuals want to be secluded. There are scientists who insist on the genetic aetiology of the disease, but the gene itself has not yet been identified (*Musliner et al., 2019*; *Pugle, 2021*). However, in the research of this article, it is noted that this personality disorder is acquired and has become a kind of

protective mechanism against stressful events, e.g., the negative treatment of parents with their children: the absence or insufficient satisfaction of basic needs and psychological violence. In this way, an adult by the age of 20–25 develops a basic sense of mistrust of the world, they expect sadistic behaviour from people in the environment, show dependence in relationships or generally avoid them to protect themselves. Such assumptions are confirmed in the research of M. Tibber et al. (*2019*), where they consider this disorder as a trust deficit. Because of this, patients tend to exaggerate any barely noticeable actions of the environment and perceive them as hostile and can react intensively to them. These beliefs become part of the patient's awareness of the influence of others on her. O. Napreyenko (*2019*) in his study explained this by the presence of alexithymia, the presence of which in the anamnesis of patients causes disturbances in relationships with people, difficulties in social adaptation and even autism.

In his research, Y. Safai (*2022*) also proves that paranoid delusion occurs in combination with other personality disorders. Y. Safai distinguishes 5 types of paranoid personalities with delusional syndrome. "Paranoid-narcissistic" manifests itself as megalomania with underdeveloped social skills. The author explains that these patients, facing an obstacle in an environment that does not recognize the omnipotence of the patient, plunge into their fantasy world and dream about their greatness there. "Paranoid-antisocial" perceives the surrounding world as hostile and responds to it with rebellious behaviour, pushing other people away from themselves. "Paranoid-compulsive"—perfectionists, self-critical, behave alienated. Tend to attribute personal shortcomings to others. "Paranoid-passive-aggressive"—irritable, negative, unable to maintain strong relationships (delusions of jealousy), socially isolated. The "decompensated" type of paranoid disorder manifests itself in psychotic episodes as a response to stress, which can later develop into psychosis.

The reason for the formation of these types is explained by Y. Safai (*2022*) in the peculiarities of raising a child, namely, the attitudes transmitted by parents to their children: "You must meet our expectations: be afraid of mistakes, not be different from others." As a result of such upbringing, a personality is formed, dependent on the opinion of the environment with broken social ties, very often becomes a victim of bullying in the children's team. Spending a lot of time in thought (especially in adolescence), such people develop a sense of loneliness, and the psyche, trying to save the individual from obsessive thoughts, forms an awareness that the cause of bullying lies in its peculiarities and envy of others. Such a defence mechanism is believed to alleviate suffering; however, delusions of grandeur reinforce social isolation and social interactions cause anxiety. Therefore, a person suffering from paranoid delusions has an internal conflict, which is depicted in Figure 4—spheres of the social environment that cause frustration (not meeting needs). And, therefore, patients want to have a family, friends, a loved one, a favourite job, however, acceptance by others will threaten the patient's system of ideas about the surrounding world, which increases a person's social isolation.

In study, L. Hinojosa-Marqués et al. (*2021*) studied the responses of a patient with paranoid delusions during a psychiatric interview using the method of computer simulation of responses developed by E. Colby in 1981. This model is based on a set of strategies that patients use to avoid shame and humiliation. L. Hinojosa-Marqués et al. investigated that the self-esteem of a person with a personality disorder who has paranoid delusions is based on the idea that he is flawed, imperfect, inadequate. When such people find themselves in a humiliating situation for

them, there is a protective reaction of the psyche—to shift the blame to others, even if this situation was created by the person with a mental disorder. By taking potentially offensive measures against people it attributes bad deeds to, one can get the same appropriate measures in return. Thus, a person suffering from paranoid delusion disorder personally increases shame and humiliation without realizing it. Feeling anger and anxiety is more acceptable for such people than shame and humiliation. In the study of J. Cosgrave et al. (*2021*) confirms the assumption that the set of symptoms that characterize paranoid delusions is a personality disorder. J. Cosgrave et al. specify that paranoid delusions include thought disorders and found that 2.2–4.4% of USA residents have social anxiety disorder.

Diagnosing paranoid delusions and establishing the causes of development requires professional skill from a psychiatrist. Patients do not often seek treatment on their and tend to spread their delusional ideas to the doctor. Long-term, systematic delirium makes it difficult for the patient to stay in the team, and therefore the medical staff can be perceived as hostile. Therefore, it is very important that the atmosphere in the medical institution is favourable and does not cause hostility. With competent treatment, the patient can get rid of symptoms or their manifestation will decrease. The complexity of such treatment lies in the responsibility borne by the patient, and when treatment is refused, the mental disorder progresses. The pathogenesis of some cases has an unfavourable prognosis, for example, patients with concomitant organic lesions of the central nervous system, chronic diseases and various types of addiction.

Conclusions

The prevalence of mental disorders among the population is a serious problem that requires an immediate solution. The development of the symptoms of some diseases takes several years, so the separation of paranoid delusions into a separate nosological unit allowed studying this disease in more detail and objectively. The best way to diagnose a personality disorder with paranoid delusions is when the stage of systematic delusions is formed. During this period, the patient associates him with the environment, which worsens relations in the family and at the workplace. Timely combined treatment stabilizes mental activity and reduces the expression of pathological symptoms, which ensures the normalization of social relations. In the absence of appropriate treatment, systematized delirium progresses and sometimes pushes the patient to commit criminal acts against the environment. However, in the research of this article, it is noted that aggressiveness is not a characteristic feature of persons with paranoid delusions. For them, rigidity and lability are more inherent—two opposite signs that form an internal personality conflict: there is a natural desire to build relationships with the surrounding world, however, they will have to get rid of their illusion about the hostility of the environment. Therefore, patients tend to independently create potentially criminal activities to approve their world-view and convince others of it.

Paranoid delusions are a component of a personality disorder, and in this study, criteria were identified by which the features of this syndrome can be determined: delusions, disorganization, suspiciousness; emotional and social alienation, limitation of contacts, apathy, stereotyped thinking; one's own life is perceived as of low quality; happy family life, having friends and love are areas in which patients feel frustrated; anxiety, introversion, rigidity, and lability—individual and typological characteristics of patients with personality disorder with schizophrenia;

distancing, escape-avoidance—behavioural strategies in stressful situations. Therefore, the prospect of further research consists in obtaining reliable data for understanding the essence of personality disorders with paranoid delusions, for this it is necessary to experimentally determine the diagnostic minimum that fully characterizes the features of the manifestation of paranoid delusions.

Conflict of Interest

The author declares that there is no conflict of interest.

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Appendix

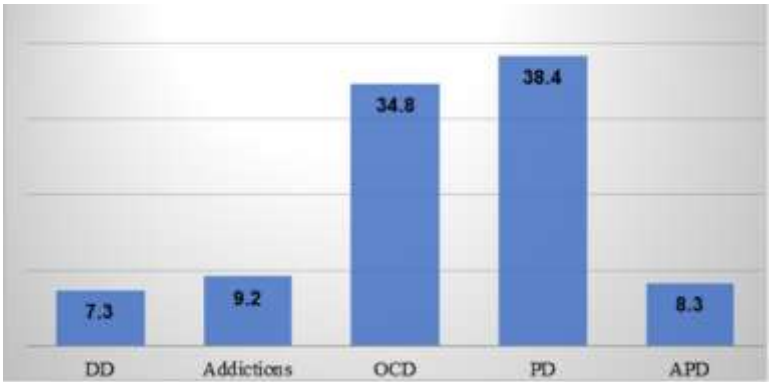

Figure 1. Results of a diagnostic examination using the psychometric method Positive and Negative Syndrome Scale

Note: DD—depressive disorder, OCD—obsessive-compulsive disorder, PD—personality disorder, APD—anxiety-phobic disorder.
Source: the author created the material based on (Napreyenko, 2019).

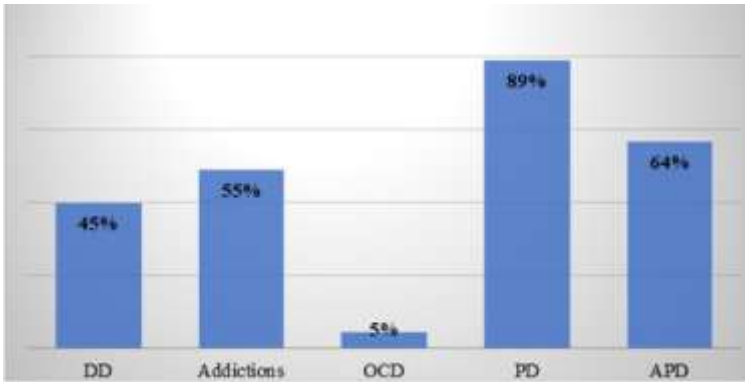

Figure 2. Diagnostic results according to the suicidal risk scale of the American Association of Suicidology

Note: DD—depressive disorder, OCD—obsessive-compulsive disorder, PD—personality disorder, APD—anxiety-phobic disorder.
Source: the author created the material based on (Syropyatov et al., 2021).

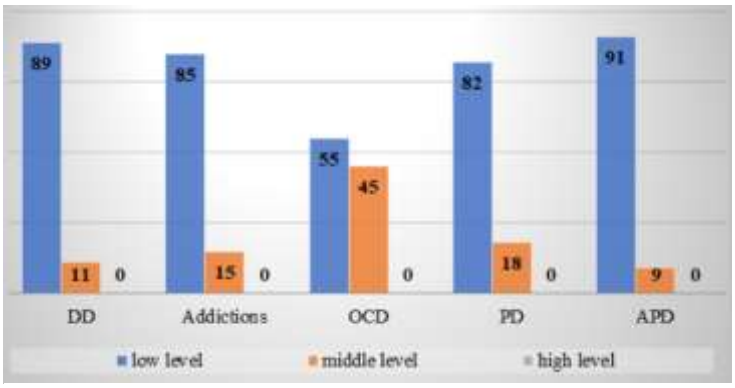

Figure 3. Diagnostic results according to the special module for patients with endogenous psychoses WHOQOL-SM (%)

Note: DD—depressive disorder, OCD—obsessive-compulsive disorder, PD—personality disorder, APD—anxiety-phobic disorder.

Source: the author created the material based on (Zhyvaho, 2021).

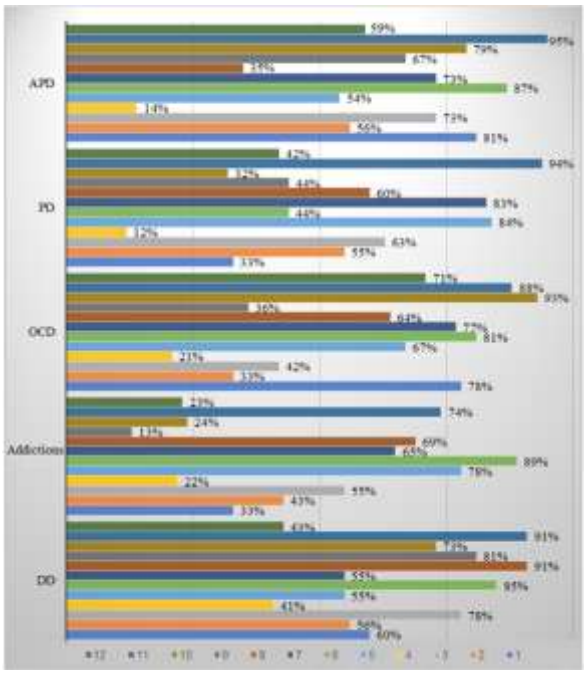

Figure 4. Results diagnosis of the level of social frustration according to the method of L.I. Wasserman in the modification of V.V. Boyko

Note: 1—active life; 2—health; 3—interesting work; 4—beauty of nature and art; 5—love; 6—material support of life; 7—presence of friends; 8—self-confidence; 9—cognition; 10—freedom; 11—happy family life; 12—creativity; DD—depressive disorder, OCD—obsessive-compulsive disorder, PD—personality disorder, APD—anxiety-phobic disorder.

Source: the material was compiled by the author based on (Stavytska et al., 2021).

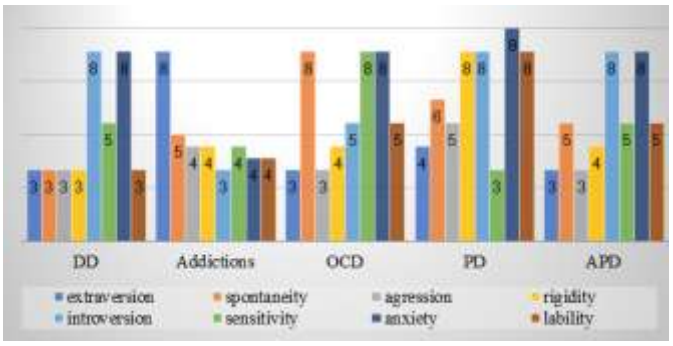

Figure 5. Results of the psychodiagnostic examination according to the individual-typological questionnaire L.N. Sobchyk (%)

Note: DD—depressive disorder, OCD—obsessive-compulsive disorder, PD—personality disorder, APD—anxiety-phobic disorder.
Source: the material was compiled by the author based on (Stavytska et al., 2021).

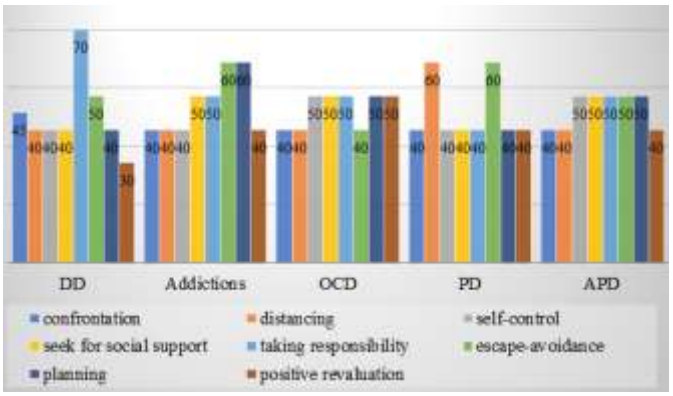

Figure 6. The results of a psychological study of the choice of behavioural strategies (%) according to the coping questionnaire Ways of Coping Questionnaire R. S. Lazarus, S. Folkman

Note: DD—depressive disorder, OCD—obsessive-compulsive disorder, PD—personality disorder, APD—anxiety-phobic disorder.
Source: the material was compiled by the author based on (Fedorchuk et al., 2020).

Table 1. Generalized data on the characteristics of the manifestation of paranoid delusions in personality disorder in schizophrenia

Symptom	Features of manifestation
Positive/negative symptoms of schizophrenia	Delirium, disorganization, suspiciousness
Suicidal behaviour	Emotional and social alienation, limitation of contacts, apathy, stereotyped thinking
Subjective perception of the level of quality of one's own life	The quality of one's own life is perceived as low
The level of social frustration	A happy family life, having friends and love are areas in which patients feel frustrated
Individual typological features	Anxiety, introversion, rigidity, and lability are individual and typological characteristics of patients with a personality disorder with schizophrenia
Style of coping strategies	Distancing, escape-avoidance—behavioural strategies in stressful situations

Source: the author compiled the material.