

Article ▶ Patients with Paranoid Symptoms: Considerations for the Optometrist

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ABSTRACT

Pathological paranoia involves a pervasive style of thinking and relating to others that is unyielding to reason and is independent of transient influences. Paranoia associated with drug abuse, neurodegenerative disease, and mental health issues will be discussed and care strategies explored. Optometrists will undoubtedly encounter patients with varying degrees and forms of paranoid symptoms. In order to provide the best possible vision care for these patients, it is essential that the optometrist be well prepared for the tension and resistance that is likely to occur during the exam. This paper will focus on patients who exhibit problematic paranoid symptoms and the relevant considerations for optometry.

Keywords: drug abuse, neurodegenerative disease, optometrist, paranoia, traumatic brain injury

Paranoid thinking is not necessarily pathological under all circumstances; it is a basic method of coping with experience that is present at times in most people throughout their lives. While in this coping mode, distressing feelings are removed from the self and are displaced upon others. Pathological paranoia, however, is independent of transient influences and involves a pervasive style of thinking and relating to others that is unyielding to reason.¹ The underlying etiology, appropriate diagnosis, and treatment of psychiatric disease is not within the optometrist's scope of practice; however, the eye care professional will almost certainly encounter patients with paranoia. The optometrist should be alert to the presentation; a respectful, empathetic, and caring attitude will allow more effective and productive encounters.

The etiology of paranoia may be mental or physical and stem from a multitude of underlying conditions. The classification of paranoid disorders has been a controversial subject throughout the history of psychiatric medicine. The most accepted classification is by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR).²

Differences between the patient's and the physician's perception of the illness can vary depending on the patient's culture and can result in poor communication and unsatisfactory treatment results.³ Paranoia can only be understood within the context of the culture to which the individual belongs. For example, tribal people of Africa, South America, and Australia have been reported to believe that having their picture taken was to have their soul stolen.⁴ If a patient from such a culture refuses retinal photography because of such a belief, this does not indicate paranoia, but rather, superstition. However, if a patient who was raised in Western culture declines the same retinal photography because he or she believe that the images will be sent to the government and used for domestic espionage, this might

be considered a paranoid delusion. A delusion is therefore an individual's false belief that is inconsistent with the beliefs of others in the same culture.⁴

The erroneous beliefs that the person is being tormented, followed, spied on, tricked, or ridiculed are notable in paranoid schizophrenia. Paranoid symptoms are also common in several other psychotic disorders including schizophreniform disorder, schizoaffective disorder, and paranoid personality disorder. Paranoid symptoms are found in almost all of the anxiety disorders such as agoraphobia, panic disorder, social phobia, obsessive-compulsive disorder, posttraumatic stress disorder, and generalized anxiety disorder.⁵ Not only are the conditions co-morbid, but patients with social phobia disorder and paranoid disorder share a similar cognitive profile and temperament.⁵ In addition to the anxiety disorders, many of the somatoform disorders include paranoid symptoms such as pain disorder, hypochondriasis, and conversion disorder. The somatoform disorders are conditions of mental illness in which a group of physical symptoms suggests a physical illness that cannot be explained by a medical condition. The DSM-IV-TR diagnostic criterion for paranoid personality disorder describes six instances where the patient may be experiencing paranoia that can be considered pathological (Table 1).¹

Schizophrenia does not vary significantly in prevalence with regard to race or gender, except that the average age of onset is mid to late 20s for men and mid to late 30s for women.² Paranoid personality disorder typically manifests first in the teenage years, occurs about twice as frequently in males than it does in females, and does not vary significantly in its prevalence with regard to race.² The prevalence of paranoid personality disorder and schizophrenia is 1-4% in the general population.²

The elderly suffer significantly from paranoia, especially when physical health and social and economic resources contribute to and aggravate this condition.⁶ Cognitive impairment and sensory deficits are significant risk factors

Table 1: Six instances of pathological paranoia as described by the DSM-IV-TR.

(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 act angrily or to counter attack.

for the development of persecutory ideation in the elderly.⁶ Although paranoid psychosis may occur for the first time after the age of 60 and is highly prevalent in older people, the appearance of delusions in a person over the age of 35 with no previous history of a primary psychotic disorder should alert the clinician to the possibility of a substance-induced psychotic disorder.^{2,3,7-9} While the patient might present to the optometrist for what appears to be visual hallucinations, the optometrist should rule out organic causes and substance abuse before suspecting the hallucinations to be of purely psychological origin. It is estimated that at least 90% of non-auditory hallucinations are the product of substance abuse or a general medical condition.³ Abuse of more than one substance at any given time is common and enhances the paranoia that occurs as a side effect.¹⁰ Substance abuse is often combined with alcohol abuse, and alcoholics score significantly higher on testing aimed at estimating paranoia.¹⁰ Chronic cocaine abuse causes paranoia, and history of prior adolescent abuse of cannabis worsens the paranoia associated with cocaine abuse.¹¹ Greater lifetime exposure to ecstasy (3,4-methylenedioxymethamphetamine) and concurrent alcohol abuse increases the likelihood of adverse effects such as paranoia, irritability, confusion, moodiness, and poor general health.¹² A significant side effect of newly-abused synthetic substances, cathinones, and methcathinone is paranoia and hallucinations.^{13,14} The abuse of these widely available psychoactive agents is on the rise in the U.S. and has become illegal within the past two years.¹³

Patients with post-traumatic stress disorder (PTSD) experience paranoid psychoses that are aggravated by substance abuse. The abuse of cannabis in this group makes the hallucinations seem more real, cocaine worsens the paranoia, and alcohol provides withdrawal hallucinosis.¹⁴ If the origin of the visual hallucinations is suspected to be heightened due to drug abuse, the optometrist should refer the patient for appropriate psychiatric examination and consider neurological imaging.

As the baby boomers age, patients with neurodegenerative disease, specifically Alzheimer's and Parkinson's disease, are

more frequently seen in optometric practice. Alzheimer's disease, over time, may lead to changes in behavior and personality that include hostility and paranoia.¹⁵ Although these encounters are distressing for the practitioner, the behavioral and psychological symptoms of dementia often cause more distress to family caregivers than professional caregivers.¹⁶ Empathy towards the caregiver may facilitate the care of the patient, especially if the care is continuous and compliance is needed for therapeutic success.

The visual variant of Alzheimer's disease presents with visual dysfunction long before the onset of dementia.¹⁷ Patients are aware of their visual dysfunction, although they may not be aware of the source of their problems. The disease affects visuospatial perception and visuo-constructional ability.¹⁷ The patient may seek to alleviate their visual and perceptual symptoms without satisfactory resolution, resulting in hostility, frustration, and heightened paranoia. These patients already have a general expectation of being exploited, and with a lack of appropriate diagnosis and multiple pairs of "useless" glasses later, this may become a self-fulfilling prophecy.¹⁸ Bright light therapy has been successfully used to reduce paranoia and agitation in certain patients with Alzheimer's disease.¹⁹

Psychosis is a severe complication of Parkinson's disease; many patients suffer paranoid delusions and other symptoms with or without dementia.^{20,21} Panic attacks are very common and easily elicited in this group.²² In addition to the already significant paranoia, REM sleep disorder is commonly associated with Parkinson's disease and autonomic dysfunction. Disordered sleep is a known trigger for paranoia and is more so for this already at-risk group.²³ Additionally, impaired color vision has been reported in patients with Parkinson's and REM sleep behavior disorder. Unfortunately, the specific type of color vision impairment was not discussed in the research article.²³

REM sleep disturbance is common in traumatic brain injury and may lead to and heighten paranoid delusions.²⁴ In addition to neuropsychiatric impairment such as chronic impairment, chronic depression, insomnia, and impaired memory, chronic traumatic brain injury may also present with paranoia.²⁵ With chronic traumatic damage the brain shows irreversible change, manifested by neurofibrillary tangles and neuritic threads. These pathological changes and findings have recently become a reason for concern in chronic head injury such as is sustained while playing American football.²⁶

Personality disorders affect approximately nine percent of the general U.S. population, and these disorders are typically classified into three clusters. Cluster A includes schizoid, schizotypal, and paranoid personality disorders.²⁷ Interestingly, left motor and sighting dominance tends to be dominant in patients with paranoid schizophrenia.²⁸ Subclinical paranoia can be divided into two types. The first type is the "poor me," in which the persecution is seen as undeserved, and the second type is "bad me," where the persecution is perceived to be deserved. Both types are unstable, poor defense mechanisms

which lead to risky behavior and substance abuse.²⁹ The “poor me” type may deliberately badmouth the optometrist if they feel slighted and may not further seek the appropriate level of care if they feel cheated. The “bad me” type might leave the optometrist’s bill unpaid. Cluster B includes borderline, histrionic, antisocial, and narcissistic personality disorders, while Cluster C includes the avoidant, dependent, and obsessive-compulsive personality disorders.²⁷

A recent study confirmed and quantified what we had long suspected. It found that 82% of Americans fear loss of vision more than any other sense.³⁰ Paranoid syndromes are often associated with disorders of vision and hearing.³¹ The vast majority (86%) of people who have, or are at risk for developing, an eye disease fear losing their vision, yet they still do not get an annual eye examination.³²

Patients with persistent mental illness receive, in general, unacceptably low levels of preventative and primary care, particularly vision care.³³ Considering that paranoia is marked by pervasive fear, it can be presumed that the fear of losing vision may be even more pervasive in this population. A paranoid person may have to be in extreme need of treatment before they seek professional help because they are not inclined to trust strangers. The patient may be in urgent or emergent situations like sudden or painful loss of vision or acute onset of flashes and floaters.³⁴

Self-inflicted ocular injury, common in paranoid-hallucinating schizophrenia, may present in practice and might be explained by the patient as traumatic eye injury without raising suspicion of self-mutilation as the etiology of the injury.³⁵ Autoenucleation is the worst form of self-mutilation of the eye associated with paranoid delusions and is often associated with suicide attempt.^{36,37} These patients are at risk and should be closely monitored with heightened vigilance, and an emergent psychiatric referral is essential.

When a paranoid patient finally consults a psychologist for treatment, the first session is almost entirely devoted to laying the groundwork of the therapeutic alliance. Alliance building is essential for paranoid patients due to their profound impairment in interpersonal relationships.³⁸ When a paranoid patient truly trusts the therapist and the treatment has been successful the termination stage of the therapy can begin.³⁶ This can take months to years to accomplish with severely paranoid individuals. The biggest challenge for the optometrist is establishing a solid working alliance in very few visits, maybe one or two in a year. The optometrist must concede at the outset that he or she will most likely not gain their patient’s trust completely. To accomplish a working alliance, the optometrist has to achieve at least an initial acceptance by the patient. The patient in turn must accept the mere possibility that the optometrist has good intentions and is capable of providing quality care.³⁹ Partial alliance can be achieved when the optometrist is aware that the paranoid patient is hyper-vigilant, and understands that the patient will look upon everything that the optometrist is doing with

suspicion. To ease this suspicion, the optometrist should verbalize his actions and intentions, explaining the purpose and function of each and every aspect of the exam process in terms that the patient can understand. Assuring the patient that his or her participation in the examination process is entirely voluntary is an important aspect of the relationship.

When giving personal and medical history, the paranoid patient may answer untruthfully, omit important information, pretend to forget things, exaggerate symptoms, or even meet questions with aggressive defiance.⁴⁰ Because of their irrational mistrust of others, the paranoid patient may believe that disclosing information such as their date of birth or which medications they take could result in somehow being harmed. Explaining the laws of patient confidentiality in detail and again reassuring the patient that their participation is voluntary may ease their resistance. It can even be helpful to acknowledge to the patient that they are being wise to be protective of their personal and medical information but that you are only asking for information that is necessary and essential for proper care.

The optometrist must carefully monitor his own reactions to the information obtained from the patient history and the exam results. If the optometrist’s speech or facial expression hints of surprise or disapproval, this may seriously damage rapport and limit both the quality and quantity of information obtained. Commenting carelessly about actions or statements made by a paranoid patient only makes the patient feel more judged or scrutinized.⁴¹ The tone of the encounter is set by both parties; the paranoid person brings only distrust to the table. The onus is completely on the caregiver to build a trusting, positive relationship, which requires remarkable self-awareness on the part of the optometrist.⁴¹

In a study by Burgener it was shown that verbal and non-verbal behaviors of caregivers are directly related to the behavior of demented elders with paranoia.⁴² The ability of the caregiver to remain relaxed and flexible is reflected by the demeanor of the patient. Patients are more likely to remain calm and cooperative if the caregiver or provider is able to maintain a positive and constructive attitude.⁴² The use of verbal distraction or redirection can be employed when the paranoid patient becomes upset. Smiling and eye contact and a playful and lighthearted approach may also be helpful.⁴² Paranoid patients will often make the practitioner understandably tense; a common tension reliever is humor. Careless joking with a paranoid patient should be avoided so as not to make the patient feel teased or ridiculed.³⁹ However, if the doctor can relieve tension by introducing humor by laughing at himself, this can alleviate some of the tension in both the doctor and the patient.³⁴

White coat syndrome is a well-known phenomenon among health care professionals, in which a patient will display elevated blood pressure in the clinical setting. Patients who show higher than average levels of anxiety show a significantly higher white coat effect than patients with normal levels of

anxiety. Ambulatory blood pressure, measured throughout the day, has been shown to be significantly lower than in-clinic blood pressure for patients who exhibit the white coat effect.⁴³ If, during the eye examination of a patient, the blood pressure is found to be in the hypertensive range, the patient should be referred to a physician to have the ambulatory blood pressure monitored.

Because the paranoid patient projects the source of their distress onto others, they are more likely to be a danger to others.³⁴ The optometrist should attempt not to provoke already heightened anxiety in the paranoid patient. Questions should be answered as honestly and completely as possible. This is obviously the best approach with all patients, but going above and beyond the usual level of disclosure might help to reduce the suspicions of the paranoid patient. The optometrist should preface all of their questions and tests with a phrase like “this is part of the routine examination that we do for all of our patients.” This can help diffuse paranoid beliefs that the optometrist is hiding something.³⁹

In terms of providing care for patients with paranoid schizophrenia, the practitioner should know what ocular pathology is likely to present during the exam. In addition to self-inflicted ocular injury, the optometrist might find reduced acuity associated with sun gazing in a delusional state. Solar retinopathy has been reported in patients with paranoid schizophrenia. The macula shows pigmentary disturbances, central and parafoveal depigmentation, and perifoveal hyperpigmentation. The visual impairment is permanent.⁴⁴

Many patients with longstanding, debilitating paranoid symptoms have a history of taking antipsychotic medications. Common antipsychotic medications are clozapine (Clozaril), loxapine (Loxitane), olanzapine (Zyprexa), and quetiapine (Seroquel). Due to their weak antagonism of H¹ receptors, these medications may have an additive effect when taken with antihistamines, and may result in increased drowsiness and lethargy during the eye exam.⁴⁵ These medications have been related to a significantly higher prevalence of anterior sub-capsular cataracts.⁴⁶ Due to their weak antagonism of α^1 adrenergic receptors, these medications may slightly inhibit mydriasis and make it more difficult to dilate the patient fully.⁴⁵ In general, patients with a psychotic illness have been shown to be more prone to physical signs and symptoms of illness such as elevated cholesterol, elevated blood pressure, and diabetes.⁴⁷ These patients should be carefully followed for development of any of these issues as well as any visual complications that may arise.

Conclusion

Optometrists will undoubtedly encounter patients with varying degrees and forms of paranoid symptoms. In order to provide the best possible vision care for these patients, it is essential that the optometrist be well prepared for the tension and resistance that is likely to occur during the exam. Maintaining a high standard of care and compassion and

being mindful of the additional needs of paranoid individuals will help overcome the urge to complete the exam hastily. Recognizing the signs of paranoia early in the exam and being equipped with the tools to form a good working relationship with these individuals will allow the optometrist to ensure that these patients receive the thorough care that they deserve.

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