Schizophrenia Bulletin Open
https://doi.org/10.1093/schizbullopen/sgag027
Advance access publication July 26, 2026

MAJOR REVIEW (ORIG)

The Lived Experience of Paranoia: Systematic Review of Qualitative Studies

Angela Muscettola[1,*]; Giulia Drusiani[1]; Martina Desenzani[1]; Ludovico Belluardo[1]; Giovanni Antonio De Bellis[1]; Lisa Bortolotti[1]; Chiara Montemitro[1]; Andrea Escelsior[2]; Luigi Zerbinati[1]; Tommaso Toffanin[1]; Rosangela Caruso[1]; Maria Giulia Nanni[1]; Luigi Grassi[1]; Martino Belvederi Murri[1]

[1]Institute of Psychiatry, Department of Neuroscience and Rehabilitation, University of Ferrara, 44121 Ferrara, Italy; [2]Section of Psychiatry, Department of Neuroscience, Rehabilitation, Ophthalmology, Genetics, Maternal and Child Health, University of Genoa, 16132 Genova, Italy

*To whom correspondence should be addressed: Angela Muscettola, Institute of Psychiatry, Department of Neuroscience and Rehabilitation, University of Ferrara, Via Fossato di Mortara 64/a, 44121 Ferrara, Italy (mscngl@unife.it)

Background and Hypothesis: **Paranoia is commonly conceptualized along a continuum ranging from transient suspiciousness and mistrust to fixed persecutory delusions. However, similar paranoid contents may differ in conviction, flexibility, self-reference, distress, functional impact, and embeddedness in broader changes of self, agency, and world-experience. We synthesized qualitative evidence on the subjective experience of paranoia, suspiciousness, mistrust, and persecutory threat.**

Study Design: **Following PRISMA and ENTREQ guidance, we searched PubMed/MEDLINE, Embase, Psyc INFO, Scopus, EBSCOhost, and Ovid from inception to January 31, 2026. Thirty-six qualitative, experiential, or mixed-methods studies were included. Data were analyzed using thematic synthesis informed by phenomenological principles. Studies were classified as core evidence when paranoia was central, or contextual evidence when paranoia-related material was embedded within broader phenomena.**

Study Results: **Three superordinate themes were generated: From interpersonal vigilance to a persecutory world; The threatened self: shame, vulnerability, trauma, and social injury; and Restoring meaning and safety: agency, coping, and altered reality. Paranoia emerged not only as a belief about threat, but as a situated transformation in the relation between self, others, and world. Lower-severity and non-clinical accounts were generally more localized, reflective, and negotiable. Clinical and higher-severity accounts were more pervasive, embodied, self-referential, and reality-defining, often intertwined with voices, external control, altered agency, spiritual meanings, or changes in reality-experience.**

Conclusions: **Paranoia is a multidimensional lived experience shaped by interpersonal threat, self-vulnerability, trauma, sociocultural context, coping, and meaning-making. Assessment should consider what paranoid beliefs mean, what they do for the person, and how they are shaped by biography, context, and lived experience.**

Key words: paranoia; psychosis; subjective experience; persecutory delusions; help-seeking; qualitative synthesis; epistemic injustice.

Introduction

Paranoia is a complex phenomenon commonly conceptualized along a continuum of severity, ranging from transient suspiciousness to fixed delusional beliefs. Despite its clinical significance, its subjective experience remains underexplored. Often referred to as persecutory thinking, paranoia has been defined as "*unfounded ideas that harm will be produced, and that the persecutor has a deliberate intention*".[1,2] Recent conceptualizations further challenge the clinical/non-clinical dichotomy by proposing that paranoia should be understood as a dimensional construct that cuts across diagnostic categories, with variations in severity ranging from subclinical mistrust—common in the general population—to more entrenched forms observed in psychiatric disorders, up to severe persecutory delusions typical of schizophrenia and delusional disorder.[1,3–5] However, this continuum should not be understood as implying simple equivalence between non-clinical suspiciousness and clinical persecutory delusions. Similar paranoid contents may differ markedly in conviction, flexibility, self-reference, emotional intensity, functional impact, and degree of

© The Author(s) 2026. Published by Oxford University Press on behalf of the University of Maryland's school of medicine, Maryland Psychiatric Research Center.
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial License (https://creativecommons.org/licenses/by-nc/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited. For commercial re-use, please contact reprints@oup.com for reprints and translation rights for reprints. All other permissions can be obtained through our RightsLink service via the Permissions link on the article page on our site—for further information please contact journals.permissions@oup.com.

embeddedness in broader changes of self, agency, and world-experience.[6–10] These experiences can profoundly impact social relationships, occupational functioning, and help-seeking behaviors while being in turn shaped and modulated by cognitive, social, psychosocial, and substance-related factors.[4,11–13]

A key challenge lies in the discrepancy between clinical assessments and lived experience, particularly because insight, conviction, and perceived plausibility may vary across the paranoia continuum.[6,8,10] Suspiciousness is frequently viewed externally as pathological, yet for many—especially those in threatening or marginalized environments—it may be perceived as adaptive. Freeman cautions against pathologizing legitimate threat perception, noting that "*real dangers exist*".[1] Adolescents report using hypervigilance to monitor unsafe contexts, and trauma survivors describe paranoia as a strategy for self-protection.[14,15] In such cases, suspiciousness may function as a coping mechanism, distinct from maladaptive forms characterized by rigidity, distress, and impairment.[1,14,15] This view is reinforced by epidemiological findings on minority stress, gendered vulnerability, and contextually grounded threat.[14,16–19]

Cognitive models have contributed substantially to the study of paranoia by examining processes such as threat anticipation, attributional style, worry, reasoning under uncertainty, and belief flexibility.[11,12] However, these processes do not fully capture the first-person meaning, relational context, and lived consequences of paranoid experience.[20–22] Qualitative studies suggest that paranoid experiences may involve a state of "parallel understanding," in which emotional conviction coexists with cognitive doubt.[6,23] This dissonance may foster confusion, withdrawal, and reinforcement of paranoid interpretations over time, especially when exacerbated by emotional dysregulation and altered time perception.[23–26]

This limited attention to subjective meaning may stem from methodological constraints. Standardized assessments often miss the complexity of lived experience.[20,21] Qualitative methods, in contrast, can uncover affective, relational, and contextual dimensions that quantitative approaches overlook.[27,28] Given the personal and emotionally charged nature of paranoid ideation, qualitative inquiry is well suited to explore how threat is experienced, interpreted, embodied, and negotiated within everyday life.[8,14,22]

Importantly, paranoia is rarely experienced as an isolated belief content. Persecutory concerns may co-occur with ideas of reference, voices, anomalous bodily experiences, altered agency, religious or grandiose meanings, and changes in the sense of self and world.[7,9,29–31] A qualitative synthesis can therefore clarify not only what people believe, but how threat becomes embedded in broader experiences of identity, agency, embodiment, and intersubjectivity.[7,8,20]

The aim of this systematic review was to synthesize the qualitative and experiential literature addressing the subjective experience of paranoia, suspiciousness, mistrust, and persecutory threat. In particular, we aimed at identifying recurrent experiential themes and to examine both continuities and differences between non-clinical paranoid experiences and clinically persecutory delusions within their personal, cultural, and social contexts.

Methods

We conducted this systematic review in accordance with the PRISMA guidelines[32] and the ENTREQ statement.[33] We designed the review as a qualitative evidence synthesis and used thematic synthesis to identify and interpret key experiential themes across clinical and non-clinical populations.[34] We developed an internal review protocol before data extraction and synthesis.

Eligibility Criteria

We included studies reporting qualitative or experiential data on the subjective experience of paranoia, broadly defined to encompass mistrust, suspiciousness, and persecutory ideation or delusion and associated experiences. Eligible studies could include clinical and community samples, provided that first-person experiential material relevant to paranoia or persecutory threat could be extracted.

Eligible designs included qualitative and mixed-methods studies using recognized qualitative or experiential approac hes. Mixed-methods studies were included only when qualitative findings could be extracted separately. Studies using quantitative or dimensionality-reduction procedures were included only when these procedures were used to organize qualitative or narrative material.

We excluded studies that were purely quantitative; mentioned paranoia only as a diagnosis, symptom label, or scale item; did not provide extractable data on paranoia, suspiciousness, mistrust, or persecutory threat; focused on a wrong population or phenomenon; were theoretical papers without primary or extractable experiential material; represented duplicate or overlapping reports; were not available in full text; or were not written in English. No restrictions were applied regarding diagnosis, age, ethnicity, or setting (Supplementary S1.1).

Search Strategy and Selection Process

We searched PubMed/MEDLINE, Embase, PsycINFO, Scopus, and databases accessible through EBSCOhost and Ovid from inception to January 31, 2026, using keywords and MeSH terms related to paranoia and qualitative research (Supplementary S1.2). All records were imported into Rayyan, which was used only for record management and duplicate removal. Titles and abstracts were screened manually by three reviewers (A.M., G.A.D.B., M.D.), followed by full-text screening of potentially eligible studies. Discrepancies were resolved through discussion or consultation with a senior reviewer (M.B.M.). We also identified additional studies through supplementary search methods, including citation chasing, screening the reference lists of included

studies and relevant reviews, and targeted searches of key sources. Reasons for full-text exclusion were recorded and grouped into standardized categories (Supplementary S1.3).

Data Extraction

Data were extracted using a structured Excel form and included study characteristics (authors, year, country, setting, design), participant demographics (sample size, gender, mean age), eligibility criteria, analytic approach, and key findings on the subjective experience of paranoia. We also recorded the use of statistical procedures, qualitative software, and thematic frameworks.

For each study, extracted material included first-order constructs, defined as participants' direct quotations or first-person accounts, and second-order constructs, defined as authors' interpretive themes, findings, or analytic explanations. Particular attention was given to how paranoia was described, whether explicitly named or indirectly represented through suspiciousness, mistrust, persecutory threat, referentiality, surveillance, control, voices, shame, trauma, or altered self-world experience. The review team checked the extracted data and resolved uncertainties through discussion.

Risk-of-Bias Assessment

Methodological quality was appraised using the 2018 CASP Qualitative Research Checklist,[35] which evaluates ten domains including aims, design, data collection, ethical conduct, and reflexivity. Two reviewers (A.M. and M.D.) independently assessed all studies, resolving discrepancies through discussion or with input from a senior reviewer (M.B.M.). In line with CASP guidance, criteria were rated descriptively ("Yes," "No," or "Can't tell") to retain interpretive nuance. Inter-rater reliability for the initial CASP ratings was calculated before consensus discussion. Quality appraisal was not used as a rigid exclusion criterion but informed the interpretation of confidence in each study's contribution to the synthesis.

Data Synthesis and Thematic Analysis

We conducted a thematic synthesis[34] in three stages: line-by-line coding of study findings, construction of descriptive themes, and generation of higher-order analytical categories. The unit of analysis included first-person quotations, participant narratives, and authors' interpretive findings directly relevant to paranoia, suspiciousness, mistrust, or persecutory threat.

Coding was primarily inductive. A.M. conducted the initial coding across all included studies using a shared coding matrix with predefined fields (e.g., study ID, excerpt, initial code, notes). G.A.D.B. independently coded a subset of studies to support analytic rigor and reflexive comparison. Codes were iteratively discussed and refined with M.B.M. through collective analytic meetings. Descriptive themes were then developed into analytical themes through constant comparison across clinical and non-clinical samples, study designs, and sociocultural contexts. The interpretive process was informed by phenomenological principles,[36] with particular attention to lived meaning, emotional tone, and temporal dynamics embedded in participants' account (Supplementary S1.4).

Core and Contextual Evidence

We distinguished between core and contextual evidence. Core studies were those in which paranoia, suspiciousness, persecutory ideation, persecutory delusions, or mistrust were a central focus of the research question, sampling strategy, interview schedule, or analysis. Contextual studies were those in which paranoia-related experiences were present and extractable, but embedded within broader phenomena such as psychosis, trauma, stigma, voice-hearing, body image, suicidal experiences, religious delusions, or therapeutic relationships.

We also used a descriptive clinical-contextual mapping to characterize the population and phenomenon represented in each study. Studies were grouped according to whether they primarily involved non-clinical paranoid experiences, trauma- or context-related mistrust, clinical psychosis-spectrum experiences, first-episode psychosis, established persecutory delusions, forensic or high-severity settings, or broader psychosis-related experiential material. This mapping was used only to describe the distribution of evidence and compare how themes appeared across different study contexts. It was not intended as a diagnostic, psychometric, or developmental severity scale.

A core-only evidence check was conducted by examining whether the main thematic structure was preserved when contextual studies were excluded (Supplementary S1.5).

Reflexivity

We used reflexive discussion throughout coding and synthesis to examine how the research team's clinical, disciplinary, and methodological backgrounds could shape interpretation. The first author (A.M.) has a clinical and rehabilitation background in psychiatry and sociology, and conducts qualitative and quantitative research on personal recovery, psychosocial functioning, and paranoia, with specific attention to the person's life context. The second (G.D.), third (M.D.), and fourth (L.B.) authors contributed through in-depth work on clinical paranoia and related psychopathological constructs. The fifth author (G.A.D.B.) contributed expertise in psychiatric rehabilitation and in the impact of clinical conditions on psychosocial functioning. The sixth author contributed expertise in philosophy, epistemic injustice, and mental health. Other authors (C.M., A.E., L.Z., T.T., R.C., M.G.N., L.G., and M.B.M.) contributed expertise in psychiatry, psychosocial research, epidemiology, and clinical psychopathology. During analytic meetings, we explicitly considered alternative interpretations and sought to avoid

reducing paranoia either to symptom content alone or to social and contextual factors alone.

Results

Study Selection

The PRISMA flow diagram summarizes the study selection process. We checked the reporting of the qualitative evidence synthesis against the ENTREQ statement. The updated database search retrieved 20 891 records. After duplicate removal in Rayyan, we screened 14 313 titles and abstracts and excluded 14 199 records. We assessed 114 full-text reports for eligibility and excluded 83 reports. We also included five additional studies identified through supplementary search methods, including citation chasing, screening the reference lists of included studies and relevant reviews, and targeted searches of key sources. The final qualitative evidence synthesis included 36 studies (Supplementary S2.1).

Study Characteristics

The synthesis comprised 36 studies, divided into 18 core evidence studies directly focused on paranoia and 18 contextual studies providing relevant material from broader clinical, phenomenological, and sociocultural perspectives (Table 1).

Most core studies involved clinical populations with psychosis-spectrum diagnoses, including schizophrenia, delusional disorder, first-episode psychosis, or clinically significant persecutory delusions.[14,17,22,23,25,29–31,37–41] A smaller number of core studies included non-clinical samples or directly compared clinical and non-clinical paranoia.[6,42–45] Contextual studies were more heterogeneous, mainly involving clinical samples but addressing paranoia-related experiences within broader phenomena such as trauma, stigma, recovery, and relational or cultural contexts,[9,10,18,24,46–57] with some contributions from non-clinical or population-based samples.[16,58]

Across studies, 1143 participants were included, with samples ranging from single cases to larger qualitative or mixed-methods designs. Most studies focused on adults, with limited representation of adolescents.[14,58] Studies were predominantly conducted in the United Kingdom, with additional contributions from Europe, North America, and other regions, and recruitment settings varied widely across clinical and community contexts.

Methodologically, most studies used cross-sectional qualitative designs based on interviews. Interpretative Phenomenological Analysis was common in core studies,[6,14,25,37,40,41] alongside thematic analysis, grounded theory, and other qualitative approaches.[17,22,23,29–31,39] Contextual studies showed greater methodological diversity, including phenomenological approaches, grounded theory, narrative analysis, and mixed qualitative designs.[10,24,47–51,53–57] Overall, the evidence base was heterogeneous but aligned with the aim of capturing the lived experience of paranoia within broader clinical and sociocultural contexts.

Risk of Bias and Methodological Quality Assessment

CASP evaluation indicated that all studies clearly articulated their research aims. Pre-consensus agreement across the 360 CASP ratings was high, with 94.2% exact agreement and substantial inter-rater reliability (Cohen's $\kappa = 0.73$). Disagreements mainly concerned the degree of transparency around recruitment, reflexivity, and the adequacy of reporting in studies that used clinical, documentary, or case-based material. These discrepancies were resolved through consensus. Agreement for the study-level clinical-contextual mapping was also high. Exact agreement was 83.3%, with substantial agreement using unweighted Cohen's kappa ($\kappa = 0.78$) and stronger agreement when the ordinal structure of the categories was considered using linear weighting (weighted $\kappa = 0.87$) (Supplementary S2.2).

Distribution of Evidence across Study Contexts

The included literature was unevenly distributed across the paranoia continuum. Most studies were based on clinical or psychosis-spectrum samples, whereas fewer studies examined non-clinical, subclinical, adolescent, or community-based experiences of suspiciousness and mistrust.[6,14,43,44] This imbalance should be considered when interpreting the synthesis, as the evidence base is richer for moderate-to-high severity paranoia and persecutory delusions than for milder or transient paranoid experiences.[17,22,25,31,37]

To address this heterogeneity, studies were organized into core and contextual evidence. Core evidence studies directly examined paranoia, suspiciousness, mistrust, persecutory ideation, or persecutory delusions as a central focus.[6,14,17,22,23,25,29–31,37–45] Contextual evidence studies contributed relevant experiential material in which paranoia-related meanings were embedded within broader phenomena, including psychosis, trauma, stigma, racism, religious experience, voice-hearing, embodiment, therapeutic relationships, or recovery.[9,10,16,18,24,46–58] Core studies provided the primary basis for the thematic synthesis, while contextual studies were used to refine, qualify, and extend the interpretation.

The study-level clinical-contextual mapping showed that interpersonal threat and mistrust were the most consistently represented experiences across the evidence base.[14,22,23,25,37] Other themes were more context dependent. Shame, trauma, stigma, and social marginalization were especially relevant where paranoia was linked to biographical or structural vulnerability.[9,14,17,49] Voice-related experiences, external control, spiritual persecution, and severe loss of agency were concentrated mainly in clinical and higher-severity contexts.[29,50,53–55] Conversely, metacognitive reflection, partial doubt, flexible coping, and help-seeking were more visible in non-clinical, subclinical, or early-stage samples[6,14,37,43,44] (Supplementary S2.3).

Study Findings

The thematic synthesis generated three superordinate experiential themes: (1) From interpersonal vigilance to a

Table 1. Table Study Characteristics

Study	Setting and sample	Participants	Qualitative design/data collection	Evidence role	Paranoia-related contribution
Aggelidou & Georgaca, 2017	International; online platform (paranoidthoughts.com). Public-domain texts from the website's "coping tips" section; one spouse-authored text excluded.	$N = 61$ texts; gender NR; age NR; assumed general-population, non-clinical contributors; service contact and diagnoses not systematically collected.	Thematic analysis; line-by-line coding of online texts; blind coding triangulation.	Core evidence	Contributors described direct coping and broader self-care strategies, linking paranoia management with quality of life and personal recovery.
Allen-Crooks & Ellett, 2014	United Kingdom; university sample. Non-clinical participants reporting an experience of believing that someone deliberately intended harm; past or present mental health problems excluded.	$N = 60$; 23.0% male; mean age 24.4 years (range 18-51); non-clinical university students.	Thematic analysis; semi-structured interviews.	Core evidence	Non-clinical suspiciousness was transient and reduced through reappraisal, reduced personalization, social support, and acceptance.
Bird, Freeman & Waite, 2022	UK; CAMHS. Adolescents aged 11-17 years with B-CAP score $\geq$23; psychosis, severe learning disability, and non-English speakers excluded.	$N = 12$; 16.7% male; mean age 14.7 years (range 11-17); clinical adolescent sample with mixed diagnoses.	Interpretative phenomenological analysis; in-depth interviews.	Core evidence	Adolescent paranoia involved multiple forms of threat shaped by trauma, peer betrayal, and sociocultural messages, and was often clinically overlooked.
Boyd & Gumley, 2007	United Kingdom; community mental health teams, rehabilitation unit, and psychiatric hospital. Current or past persecutory delusions meeting Freeman and Garety's criteria.	$N = 10$; 90.0% male; mean age 38.7 years (range 26-54); clinical sample with current or past persecutory paranoia.	Constructivist grounded theory; 15 semi-structured interviews with 10 participants.	Core evidence	Persecutory paranoia was organized around fear, vulnerability, and confusion, with safety behaviors providing short-term protection while reinforcing withdrawal.
Campbell & Morrison, 2007	United Kingdom; University of Manchester and community mental health teams. Clinical group with schizophrenia-spectrum disorder and paranoia; non-clinical group endorsing PDI paranoia items.	$N = 12$; 50.0% male; mean age 30.9 years (range NR); schizophrenia-spectrum disorder vs non-clinical university sample.	Interpretative phenomenological analysis; semi-structured interviews; PDI screening for non-clinical participants.	Core evidence	Clinical participants reported less control and greater powerlessness than non-clinical participants, although both groups described anxiety and a partly protective function.
Dickson et al., 2016	UK; three NHS teams. Participants with previous persecutory delusions but no persecutory delusions during the 8 months before interview.	$N = 7$; 85.7% male; mean age 34.0 years (range 18-43); mainly paranoid schizophrenia and delusional disorder.	Interpretative phenomenological analysis; narrative interviews.	Core evidence	Past paranoia was linked to relational adversity, victimization, and fractured self-concept, alongside avoidant and adaptive coping.

(Continued)

Table 1. Continued.

Study	Setting and sample	Participants	Qualitative design/data collection	Evidence role	Paranoia-related contribution
Fierro et al., 2018	Colombia; clinical research setting, Bogotá. Participants with delusions of control in schizophrenia or schizophreniform disorder; relevant comorbidities excluded.	$N = 7$; 85.7% male; mean age 33.0 years (range NR); schizophrenia or schizophreniform disorder.	Phenomenological clinical interviews.	Core evidence	Delusions of control were embedded in persecutory narratives involving hostile agents and shaped by cultural and biographical frameworks.
Fornells-Ambrojo & Garety, 2005	United Kingdom; early psychosis services, South London. First or second psychotic episode with persecutory delusions; psychiatric history longer than 5 years excluded.	$N = 40$; 70.0% male; mean age 26.5 years (range NR); acute early psychosis with schizophrenia, schizophreniform, or schizoaffective disorder.	Semi-structured qualitative interview with complementary quantitative measures.	Core evidence	Poor-me paranoia predominated; bad-me paranoia was uncommon and associated with guilt, depression, and low self-esteem.
Gordon et al., 2023	United States; archival BPRS interviews from community-dwelling outpatients in California and Massachusetts. Non-Hispanic White or Black adults with schizophrenia or schizoaffective disorder.	$N = 21$; 61.9% male; mean age 47.2 years (range 29-60); schizophrenia or schizoaffective disorder; 12 White and 9 Black participants.	Retrospective thematic content analysis of archival BPRS interviews; line-by-line coding of referential, persecutory, and cultural themes.	Core evidence	Paranoia involved reference, persecution, and cultural mistrust; Black participants more often described persecutory content related to safety and danger.
Green et al., 2006	UK; four NHS Trusts. Current persecutory delusion; PANSS suspiciousness/persecution ≥ 4 and SAPS delusion item ≥ 3.	$N = 70$; 71.4% male; mean age 41.5 years (range 20-65); schizophrenia or schizoaffective disorder.	Cross-sectional content analysis of clinical interviews describing persecutory beliefs.	Core evidence	Persecutors were often powerful, organized, supernatural, or personally known, with harm perceived as imminent or ongoing.
Harper et al., 2021	United Kingdom; university sample, London. Non-clinical participants with high paranoia scores; current psychiatric patient status and primarily drug-influenced experiences excluded.	$N = 7$; 14.3% male; mean age 28.1 years (range 20-36); non-clinical university sample with high self-reported paranoia.	Thematic analysis; narrative interviews.	Core evidence	Non-clinical paranoia was socially meaningful and shaped by mistrust, bullying, gendered threat, and ambiguous interactions.
Jones et al., 2021	UK; Early Intervention for Psychosis Services, London. Participants with first-episode psychosis within 3 years; non-English speakers excluded.	$N = 160$; 50.0% male; mean age 23.7 years (range NR); clinical first-episode psychosis sample with mixed diagnoses.	Retrospective thematic analysis of clinical records and interviews.	Core evidence	First-episode narratives included harm, surveillance, deception, control, supernatural content, and service mistrust.

(Continued)

Table 1. Continued.

Study	Setting and sample	Participants	Qualitative design/data collection	Evidence role	Paranoia-related contribution
Lawlor et al., 2015	UK; NHS services. Clients with paranoid schizophrenia, current persecutory delusions, and current CBTp engagement; therapists were NHS clinical psychologists.	$N = 18$ (8 clients; 10 therapists); clients 100.0% male, therapists 50.0% male; client mean age 35.9 years (range 31-41).	Thematic analysis; parallel semi-structured interviews with clients and therapists; respondent validation.	Core evidence	Paranoia about therapists affected trust and engagement; openness, validation, and radical collaboration supported the therapeutic relationship.
Marshall et al., 2019	United Kingdom; NHS outpatient services, Oxford. Adults with current or historical persecutory delusions and non-affective psychosis; acute psychosis, high risk, and primary substance misuse excluded.	$N = 12$; 50.0% male; mean age 43.0 years (range 19-58); paranoid schizophrenia, schizoaffective disorder, or psychosis NOS.	Interpretative phenomenological analysis; semi-structured interviews; reflexive log and audit trail.	Core evidence	Body-image concerns amplified paranoid ideation, humiliation, withdrawal, and loss of agency.
Mosley et al., 2017	USA; online community survey. Black men endorsing MCMI-III Paranoid scale items and providing open-ended explanations.	$N = 104$ surveyed; 86 included in qualitative analysis; 100.0% male; mean age 35.1 years (range NR); non-clinical community sample of Black men.	Modified consensual qualitative research; open-ended survey responses; consensus coding and audit.	Core evidence	Mistrust often reflected betrayal, discrimination, and oppression, challenging culturally decontextualized interpretations of paranoia.
Sher et al., 2025	United Kingdom; NHS mental health services. Participants recovering from persecutory delusions, defined by low conviction/distress and non-clinical R-GPTS Part-B score; acute symptoms and high risk excluded.	$N = 15$; 66.7% male; mean age 43.5 years (range 23-56); clinical sample with previous severe paranoia, mainly non-affective psychosis.	Interpretative phenomenological analysis; semi-structured interviews; PPI involvement, reflexive memos, and audit trail.	Core evidence	Recovery involved rebuilding safety through trust, support, routine, meaningful activity, and alternative explanations.
Startup et al., 2015	UK; Oxford Health NHS Foundation Trust and Southern Health NHS Foundation Trust. Persistent persecutory delusion in non-affective psychosis and clinically significant worry; current CBT excluded.	$N = 8$; 62.5% male; mean age 44.3 years (range 20-58); schizophrenia, psychosis NOS, schizoaffective disorder, or delusional disorder.	Interpretative phenomenological analysis; semi-structured interviews focused on how worry episodes ended.	Core evidence	Worry was intrusive and difficult to stop, reinforcing persecutory beliefs; distraction, support, and reality-testing could help.

(Continued)

Table 1. Continued.

Study	Setting and sample	Participants	Qualitative design/data collection	Evidence role	Paranoia-related contribution
Stopa et al., 2013	United Kingdom; outpatient and clinical services. Social-phobia group and paranoia group with schizophrenia and persecutory delusions; DSM-IV diagnoses confirmed using the SCID.	$N = 18$ (9 paranoia; 9 social phobia); overall 38.9% male; paranoia group 55.6% male; mean age 37.8 years (range 20-58).	Thematic analysis; adapted cognitive profiling interview; semi-structured interviews.	Core evidence	Compared with social anxiety, paranoia involved more intentional threat, salient persecutors, and persistent conviction in danger.
Canta et al., 2019	Portugal; state psychiatric hospital, day hospital, and outpatient care. Pharmacologically stabilized participants with paranoid schizophrenia able to participate with family involvement.	$N = 5$ participants plus family members; 60.0% male; mean age 25.6 years (range 17-38); paranoid schizophrenia.	Psychodynamic grounded theory; semi-structured interviews with participants and family members.	Contextual evidence	Paranoia was interpreted as a defensive process preserving a fragile identity, shaped by trauma, loss, and family dynamics.
Coughlan et al., 2021	Ireland; population-based longitudinal Adolescent Brain Development cohort. Young adults with childhood history of hallucinations and/or delusions and follow-up participation.	$N = 17$; 58.9% male; mean age 19.0 years (range 18-21); general-population sample; 82.4% had lifetime Axis I disorder.	Descriptive phenomenology; longitudinal content analysis of clinical interview notes and early-adult qualitative interviews.	Contextual evidence	Paranoid ideation appeared within a distressing pathological trajectory, unlike culturally integrated paranormal experiences.
Dimaggio et al., 2006	Italy; cognitive psychotherapy center, Rome. Idiographic psychotherapy case with paranoid personality disorder.	$N = 1$; 0.0% male; age 27.0 years; paranoid personality disorder.	Narrative case study; Dialogical Self Theory; diary analysis and longitudinal therapy observation.	Contextual evidence	Paranoia reflected a restricted dialogue between an inadequate self and an abusive other; therapeutic change involved new self-positions and narrative enrichment.
Drinnan & Lavender, 2006	United Kingdom; community mental health and assertive outreach teams. Participants with delusions who self-identified as religious; acute psychosis or serious distress at interview excluded.	$N = 7$; 85.7% male; age range 30-53 years; clinical sample with delusions.	Grounded Theory; semi-structured interviews.	Contextual evidence	Religious beliefs provided a framework for persecutory and grandiose experiences and for negotiating identity.
Franco & Nicholls, 2023	United Kingdom; autobiographical single case. Autobiographical account; formal inclusion criteria not applicable.	$N = 1$; 0.0% male; age NR; previous diagnosis of paranoid schizophrenia, in remission.	Psychoanalytic autoethnography; diaries, Jungian analysis, and self-analysis.	Contextual evidence	Psychosis was interpreted as symbolic meaning-making around sexual trauma, while professional invalidation delayed recovery.

(Continued)

Table 1. Continued.

Study	Setting and sample	Participants	Qualitative design/data collection	Evidence role	Paranoia-related contribution
Gooding et al., 2023	United Kingdom; NHS mental health services, Northwest England. Adults with non-affective psychosis and suicidal experiences within the previous 3 months; dementia or organic brain disorder excluded.	$N = 22$; 50.0% male; mean age 37.6 years (range 18-62); mainly schizophrenia, schizoaffective disorder, or persistent delusional disorder.	Inductive reflexive thematic analysis; semi-structured interviews.	Contextual evidence	Feeling watched, judged, or threatened intensified anxiety, withdrawal, and disconnection within the suicidal process.
Green et al., 2018	United States; maximum-security forensic hospital system, Connecticut. Naturalistic forensic sample identified by clinicians as currently or previously experiencing delusions.	$N = 17$; 100.0% male; mean age 42.6 years (range 26-62); forensic clinical sample with heterogeneous diagnoses.	Mixed qualitative study; semi-structured interviews adapted from the Maudsley Assessment of Delusions; qualitative coding and belief-strength ratings.	Contextual evidence	Delusions varied in action-guidance, justification, and evidence sensitivity, supporting a continuum of belief-likeness.
Jones et al., 2018	United States; public mental health agencies, Hearing Voices Network groups, and advocacy listservs. Adults with experience of psychosis and past or current treatment.	$N = 49$; 55.1% male overall; interview mean age 39.0 years (range 18-67); past or current treatment for psychotic disorder, mainly schizophrenia-spectrum diagnoses.	Phenomenological and qualitative content analysis; in-depth interviews and secondary analysis of focus groups.	Contextual evidence	Sexual and gendered psychotic experiences involved shame, persecution, violence, power, and agency.
Lazaridou et al., 2022	Germany; online interviews, Berlin. First- and second-generation migrants racialized as Black or People of Color living in Germany.	$N = 20$; 35.0% male; age NR; non-clinical sample, no psychiatric diagnosis reported.	Constant comparative method; semi-structured interviews; intersectionality and Black feminism framework.	Contextual evidence	Racism was linked to chronic anticipation of harm, hyper-alertness, distrust, and self-questioning.
Mohr et al., 2010	Switzerland and Canada; psychiatric outpatient settings. Participants with schizophrenia or schizoaffective disorder.	$N = 236$; 65.0% male; mean age 42.9 years (range NR); schizophrenia or schizoaffective disorder.	Mixed quantitative and qualitative assessment of religiosity and religious coping; clinical and narrative interviews.	Contextual evidence	Religious delusions could involve persecution, punishment, possession, and control, while spirituality had both supportive and distressing effects.
Morrison et al., 2002	UK; specialist psychosis service, Manchester. Participants with active hallucinations and/or delusions receiving cognitive therapy.	$N = 35$; 65.7% male; mean age 33.7 years (range 18-54); schizophrenia, schizoaffective disorder, or schizophreniform disorder.	Exploratory descriptive qualitative study; semi-structured interview on mental images associated with psychotic symptoms.	Contextual evidence	Mental imagery linked affect, traumatic memories, and psychotic symptoms, sometimes reinforcing paranoid beliefs.

(Continued)

Table 1. Continued.

Study	Setting and sample	Participants	Qualitative design/data collection	Evidence role	Paranoia-related contribution
Pietkiewicz et al., 2021	Poland; trauma and dissociation research center. Participants diagnosed with schizophrenia who had been labeled as possessed by religious communities and had contact with exorcists.	$N = 4$; 50.0% male; mean age 26.5 years (range 21-30); schizophrenia; Roman Catholic participants.	Interpretative phenomenological analysis; in-depth clinical interviews and psychiatric assessment.	Contextual evidence	Possession beliefs were shaped by trauma and religion; exorcism could reinforce delusional interpretations and delay psychiatric treatment.
Pratiwi et al., 2025	Indonesia; psychiatric hospital, Central Java. Adults with schizophrenia and delusional experiences admitted to a non-acute ward and able to communicate.	$N = 30$; 70.0% male; age NR; undifferentiated schizophrenia or paranoid schizophrenia.	Interpretative phenomenological analysis with thematic elements; repeated interviews, observation, and family triangulation.	Contextual evidence	Javanese cultural frameworks shaped delusional content involving spirits, demonic forces, and magical powers.
Rhodes & Healey, 2016	United Kingdom; hospital-based psychology department and community mental health team. Participants with psychosis and childhood physical abuse above CTQ threshold; documented sexual abuse excluded.	$N = 8$; 62.5% male; age range 23-53 years; psychosis-spectrum sample with varied diagnoses.	Interpretative phenomenological analysis; semi-structured interviews; independent double analysis.	Contextual evidence	Paranoia appeared as pervasive mistrust within an aggression-saturated world linked to childhood physical abuse.
Rhodes et al., 2015	United Kingdom; mental health services for refugees and asylum seekers. Refugees or asylum seekers with psychosis or psychotic symptoms able to participate in interviews.	$N = 7$; 85.7% male; age NR; clinical refugee and asylum-seeker sample with psychotic symptoms.	Interpretative phenomenological analysis; in-depth semi-structured interviews.	Contextual evidence	Paranoia was embedded in violence, forced migration, and loss, with difficulties rebuilding safety and belonging.
Ritunnano et al., 2026	UK; Early Intervention in Psychosis services. Adults with first-episode psychosis and past or current clinically significant delusions; relevant exclusions included substance-induced psychosis and intellectual disability affecting consent.	$N = 10$; 30.0% male; median age 24.5 years; first-episode psychosis with mixed diagnoses; 10% non-binary.	Qualitatively driven multimethod study; phenomenological and narrative interviews, including EAWE.	Contextual evidence	Persecutory delusions emerged as embodied emotional processes rooted in shame, fear, and anger.
Ternamian et al., 2025	France; first-episode psychosis program, Greater Lyon. Adults aged 18-35 years with first-episode psychosis; IQ <70, marked disorganization, and active suicidal crisis excluded.	$N = 17$; 58.8% male; age range 18-35 years; first-episode psychosis with mixed diagnoses.	Thematic content analysis; semi-structured interviews, TALE checklist, matrix coding, and cluster analysis.	Contextual evidence	Participants linked trauma with psychotic symptoms, including bullying with persecutory delusions and abuse with control-related content.
Tully et al., 2017	United Kingdom; mental health services in Northwest England. Experience of schizophrenia, schizoaffective disorder, psychosis, or psychotic-like experiences; age 16-65 and regular contact with a health professional.	$N = 15$; 66.7% male; mean age 36.6 years (range 21-61); clinical sample including schizophrenia, paranoid schizophrenia, first-episode psychosis, and psychosis.	Social constructivist Grounded Theory; in-depth semi-structured interviews; iterative coding, theoretical sampling, and member checking.	Contextual evidence	Threat appraisal, perceived control, and safety behaviors shaped coping, and some protective strategies were grounded in real past threats.

Abbreviations: B-CAP = Brief Core Assessment of Paranoia; BPRS = Brief Psychiatric Rating Scale; CAMHS = Child and Adolescent Mental Health Services; CBTp = cognitive behavioral therapy for psychosis; CTQ = Childhood Trauma Questionnaire; EAWE = Examination of Anomalous World Experience; MCMI-III = Millon Clinical Multiaxial Inventory-III; NHS = National Health Service; NR = not reported; PANSS = Positive and Negative Syndrome Scale; PDI = Peters et al. Delusions Inventory; PPI = patient and public involvement; PSWQ = Penn State Worry Questionnaire; R-GPTS = Revised Green et al. Paranoid Thoughts Scale; SAPS = Scale for the Assessment of Positive Symptoms; SCID = Structured Clinical Interview for DSM.

Table 2. Overview of Superordinate Themes

Superordinate theme	Experiential focus	Main pattern across the continuum
From interpersonal vigilance to a persecutory world	Mistrust, hypervigilance, perceived observation, ideas of reference, and persecutory interpretations of others' intentions	In milder accounts, threat was localized, situation-bound, and open to doubt; in clinical and higher-severity accounts, interpersonal threat became pervasive, self-referential, and world-organizing.
The threatened self: shame, vulnerability, trauma, and social injury	Shame, self-vulnerability, bodily exposure, trauma, stigma, racism, gendered threat, and relational insecurity	In lower-severity accounts, the self could feel threatened without being fully reorganized by the threat; in clinical and contextual accounts, shame, trauma, stigma, and social injury shaped the meaning and location of persecutory experience.
Restoring meaning and safety: agency, coping, and altered reality	Avoidance, withdrawal, reassurance-seeking, reality-testing, routines, help-seeking, spiritual interpretation, voices, external control, and delusionally organized explanations	In milder accounts, coping and meaning-making remained relatively flexible; in higher-severity accounts, the search for safety and coherence could become rigid, isolating, and embedded within delusional reality.

persecutory world; (2) The threatened self: shame, vulnerability, trauma, and social injury; and (3) Restoring meaning and safety: agency, coping, and altered reality. Table 2 summarizes the experiential focus of each theme and its main pattern across the paranoia continuum (Supplementary S2.4).

From Interpersonal Vigilance to a Persecutory World. "*It means fear*".[22] This concise participant account captures the affective core of the first superordinate theme: the transformation of ordinary interpersonal caution into a pervasive experience of being watched, judged, followed, controlled, or targeted. Across the evidence base, paranoia was consistently anchored in the social field: other people were not neutral background figures, but possible sources of scrutiny, humiliation, betrayal, or harm.[14,17,22,38,43,44] This theme included mistrust, hypervigilance, perceived observation, ideas of reference, fear of being harmed, and persecutory interpretations of ambiguous social cues.[23,25,30]

In non-clinical and lower-severity samples, suspiciousness was typically selective, situation-bound, and at least partly open to reflection.[42–45] Participants could identify suspicious thoughts as exaggerated, stress-related, or linked to previous interpersonal experiences, while hypervigilance often retained a protective function: a way of monitoring potentially unsafe environments while preserving some contact with shared reality.[42,44,45]

In adolescent and emerging-adult samples, the interpersonal field became more unstable and emotionally charged.[14,31] Vigilance could persist even in places expected to feel safe, as one adolescent described: "*Even at home where everything you think is safe, you still have to look out for people*".[14] Participants could sometimes recognize that their interpretations might be excessive, but in moments of acute fear "*all logic will fly out the window*", making disengagement difficult.[14] Mistrust could extend from strangers to peers, family members, teachers, or professionals, making help-seeking ambivalent.[31]

In clinical and higher-severity samples, interpersonal threat became more pervasive, less negotiable, and more tightly connected with self-reference.[22,25,37,38] Participants described being watched through phones, monitored by unknown others, followed in public spaces, targeted by groups, or spoken about by people around them. Ideas of reference intensified the sense that ordinary gestures, looks, conversations, or media messages were personally directed.[25,30] Everyday interactions became saturated with persecutory meaning, as participants described people "*whispering behind my back*" or looking with an "*evil look in their eyes*".[17]

At the highest levels of clinical severity, the persecutory world became global and difficult to delimit.[17,29,41] Mistrust extended beyond specific people or contexts to institutions, services, technologies, supernatural agents, or the structure of reality itself. Voice-related experiences, surveillance, thought-reading, technological control, spiritual attack, or coordinated persecution could become part of a broader transformation of the person's lived world into a hostile environment.[50,51,53,55] In one account, fear and mistrust were organized through a possession framework: "*I was frightened and distrusted people*" and the only explanation available was being "*possessed by someone else*".[29]

Contextual studies on racism, institutional betrayal, and marginalization further showed that suspiciousness could not always be separated from real histories of surveillance, exclusion, or social threat.[16–18] These findings do not reduce clinical paranoia to a realistic appraisal of social danger; rather, they suggest that persecutory meanings may be shaped by both actual social injuries and psychotic processes.

Taken together, these findings suggest that what changes across study contexts is not simply how strongly threat is believed, but how widely it reorganizes interpersonal life. In

milder accounts, suspiciousness remained relatively localized, open to doubt, and linked to identifiable social situations; in clinical and higher-severity accounts, interpersonal threat became increasingly pervasive, self-referential, and world-organizing. The person increasingly inhabited a relational world structured around hostile attention, surveillance, and persecution.

The Threatened Self: Shame, Vulnerability, Trauma, and Social Injury. "*I don't like myself because I'm afraid all the time of other people*".[14] This participant account captures the affective and self-related core of the second superordinate theme: paranoia was not only organized around external threat, but also reshaped the person's sense of worth, identity, bodily exposure, and relational safety.[6,37,40,49,56] Across studies, participants described feeling defective, exposed, guilty, humiliated, contaminated, powerless, or fundamentally unsafe in relation to others.[40,47,54,56]

In non-clinical samples, self-related vulnerability was often linked to social evaluation, rejection sensitivity, embarrassment, or previous exclusion.[43,44] Shame and anxiety were present but usually did not fully reorganize identity: the person could still distance themselves from the paranoid thought and locate it within stress, insecurity, or a specific interpersonal situation.[45]

In young people and subclinical samples, shame and vulnerability became more central.[14,49] Paranoia restricted the expected freedoms of adolescence, as one participant stated: "*I should be able to go out with my friends and enjoy my time, I shouldn't have to worry about being kidnapped or murdered . . . because I'm only 15*".[14] For some adolescent girls and young women, suspiciousness was shaped by sexualized scrutiny, fear of harassment, and the need to manage gendered threat.[14] Repeated exposure to fear, humiliation, or exclusion appeared to narrow the possibility of trusting others, increasing the likelihood that ambiguous social cues would be interpreted as hostile.[49]

In clinical samples, traumatic and relational histories were more frequently described as formative contexts for paranoia.[6,37,49,56] Childhood adversity, bullying, abuse, neglect, family conflict, institutional harm, racism, sexual trauma, and social defeat shaped expectations of betrayal and danger and provided a background against which persecutory meanings developed.[6,17,49,56] In Dickson et al. (2016), one participant described this shift as reaching the conclusion that "*the world is a dangerous place*", while another described relational protection through a defensive "*wall*" that kept others at a distance. In Franco and Nicholls (2023), the link between trauma and paranoia was made explicit: "*My delusional, or paranoid, world had profound meaning and was the production of a 'reality' of trauma that had been denied*".[56] Shame and guilt could also shape the moral tone of persecutory experience, especially when persecution felt connected to being bad, guilty, contaminated, or defective.[38,40]

Contextual evidence deepened this interpretation by showing how paranoia-related experiences may become embodied.[9,53–55] The self was sometimes experienced as visible, exposed, invaded, or transparent to others. In Ritunnano et al. (2026), this exposure was expressed as a fear of "*being seen*" and a wish to be "*invisible*," with the participant describing the feeling that outside the home "*everything is watching me*".[9] This pattern links interpersonal threat with altered self-experience: the danger is not only that others may harm the person, but that the boundary between private self and public world becomes unstable.

Stigma and marginalization further intensified this threatened self.[16–18] In racialized or socially marginalized groups, mistrust was often embedded in histories of racism, institutional surveillance, police threat, poverty, or exclusion.[17] Clinical stigma could also enter the paranoid field when services, clinicians, diagnosis, or medication were experienced as threatening, coercive, or invalidating, especially when the person felt unheard or epistemically discredited.[24,57]

Taken together, these findings suggest that the self is not merely the target of paranoid threat, but one of the places where threat is experienced and organized. Shame, trauma, stigma, racism, and gendered vulnerability did not simply appear as background risk factors; they shaped how threat was interpreted, where it was located, and why it became personally meaningful. In this sense, paranoia emerged as both relational and self-involving: a way of making sense of danger that could preserve meaning and protection, while also deepening exposure, isolation, and mistrust.

Restoring Meaning and Safety: Agency, Coping, and Altered Reality. "*I prefer being inside or where I live because no-one knows where I live*".[14] This participant account captures the practical and protective core of the third superordinate theme: in the face of paranoid threat, individuals did not only experience fear or vulnerability, but actively tried to restore safety, coherence, and agency. Across studies, these attempts included avoidance, withdrawal, reassurance-seeking, distraction, reality-testing, routines, help-seeking, disengagement from services, and efforts to make sense of voices, bodily experiences, spiritual meanings, or perceived external control.[24,25,38,40,50,51] This theme therefore concerns what paranoid beliefs and related behaviors did for the person: how they protected, explained, contained distress, restored control, or organized experience.

In non-clinical and lower-severity samples, coping was generally flexible and intentional.[43–45] Participants described distraction, social support, selective avoidance, self-talk, and attempts to test the plausibility of suspicious thoughts.[44] Meaning-making also remained open: suspiciousness could be understood through stress, insecurity, fatigue, interpersonal conflict, or emotional vulnerability.[45] In these accounts, coping helped participants maintain distance from paranoid thoughts and preserve some contact with shared reality.

In adolescent and early-stage samples, coping became more ambivalent.[14,31] Withdrawal, environmental scanning, avoiding eye contact, staying away from people, or relying on trusted others could reduce immediate distress, but also

limited participation and reinforced isolation. Suspiciousness also fluctuated across contexts, intensifying at night, in crowded places, during loneliness or stress, or after perceived rejection.[31] Coping was therefore not only a response to paranoia, but part of how the person negotiated where safety could still be found.

In clinical samples, coping was more constrained and less consistently effective.[24,25,40] Avoidance, isolation, compulsive checking, substance use, reassurance-seeking, and other safety behaviors could reduce immediate fear while maintaining threat anticipation.[25] Participants also described trying to resist or ignore voices, avoid triggering situations, seek confirmation from others, or use routines to stabilize experience.[51] Help-seeking was similarly ambivalent: services could provide containment and support, but could also be avoided when professionals, diagnosis, medication, or coercive care were incorporated into the threat system.[24,57]

As paranoia intensified, meaning-making became increasingly central.[40,50,55] Participants tried to explain why threat was happening, why they had become its target, and how it could be resisted or survived. Religious and spiritual frameworks were especially complex: in some accounts they provided comfort, structure, hope, or moral orientation; in others, they organized meanings of punishment, possession, curse, divine testing, special mission, or spiritual persecution.[50,55] Similarly, voice-related experiences could function as threat, explanation, relationship, or command depending on how they were understood and managed.[51]

At higher levels of severity, the attempt to restore coherence could become inseparable from delusional reality itself.[9,29,41] External control, thought interference, technological surveillance, possession, spiritual attack, or being chosen by powerful agents were not merely additional symptoms, but organizing frameworks through which overwhelming experiences of fear, confusion, bodily alteration, and loss of agency could be explained.[9,29,55] The paranoid system could therefore provide coherence while also reducing freedom: it explained the threat but trapped the person inside a world governed by hostile or controlling forces.

Taken together, these findings suggest that coping and meaning-making in paranoia cannot be understood simply as adaptive or maladaptive. In milder forms, strategies such as distraction, selective avoidance, social support, and reflective distancing could preserve flexibility and contact with shared reality. In clinical and higher-severity forms, the same search for safety could become more rigid, isolating, and delusionally organized. The clinical implication is that assessment should not ask only whether a paranoid belief is present, but what work that belief is doing for the person: whether it protects, explains, restores agency, justifies withdrawal, or gives structure to an otherwise overwhelming experience.

Integrative Synthesis across the Continuum

Taken together, the three superordinate themes indicate that paranoia was not experienced only as a persecutory belief, but as a situated transformation in the relation between self, others, and world. The first theme showed how ordinary interpersonal vigilance could become a persecutory social world. The second showed how this threat also reshaped the person's sense of self, bodily exposure, shame, and relational safety. The third showed how individuals attempted to restore safety, coherence, and agency through coping strategies, meaning-making, withdrawal, help-seeking, or delusionally organized explanations. Figure 1 summarizes this integrative model, representing the three domains as dimensions that operate across the continuum rather than as separate severity stages.

Across the continuum, the difference between milder and more severe forms of paranoia was not only quantitative. In lower-severity and non-clinical accounts, suspiciousness was more often localized, reflective, and negotiable. Participants could link paranoid thoughts to stress, insecurity, social evaluation, previous exclusion, or environmental threat, while retaining some capacity to question their interpretations and use flexible coping strategies.[6,14,43,44] In clinical and higher-severity contexts, by contrast, paranoia became more pervasive, embodied, and reality-defining. Interpersonal threat extended beyond specific situations; shame and vulnerability became more closely tied to identity; agency was increasingly compromised; and meaning-making became less flexible.[17,22,25,37,49]

The core/contextual evidence distinction clarified both the robustness and the limits of the synthesis. Interpersonal threat, mistrust, hypervigilance, shame, coping, and altered agency were supported by paranoia-focused studies, whereas trauma, racism, stigma, embodiment, therapeutic relationships, religious experience, voice-hearing, and broader alterations of self and world were mainly elaborated through contextual evidence.[9,17,49,50,53,54] A core-only evidence check indicated that the main thematic structure remained stable when contextual studies were excluded, although subthemes such as systemic marginalization, spiritual persecution, body-related threat, indirect family exposure to paranoia, and broader embodied alterations of reality should be interpreted as context dependent rather than universal features of paranoia.

Discussion

We reviewed qualitative studies examining the subjective experience of paranoia across clinical, non-clinical, and contextual populations. We found that paranoia cannot be adequately understood only as a belief that others intend harm. Although perceived interpersonal threat remains central to the construct,[1,12] our synthesis shows that paranoia is also an affective, relational, embodied, and meaning-making experience. Across studies, paranoid experience involved changes in how individuals perceived others, experienced themselves as exposed or vulnerable, and attempted to restore safety, coherence, and agency.[14,17,22,23,25]

Our findings are consistent with cognitive models of paranoia, which emphasize threat anticipation, worry,

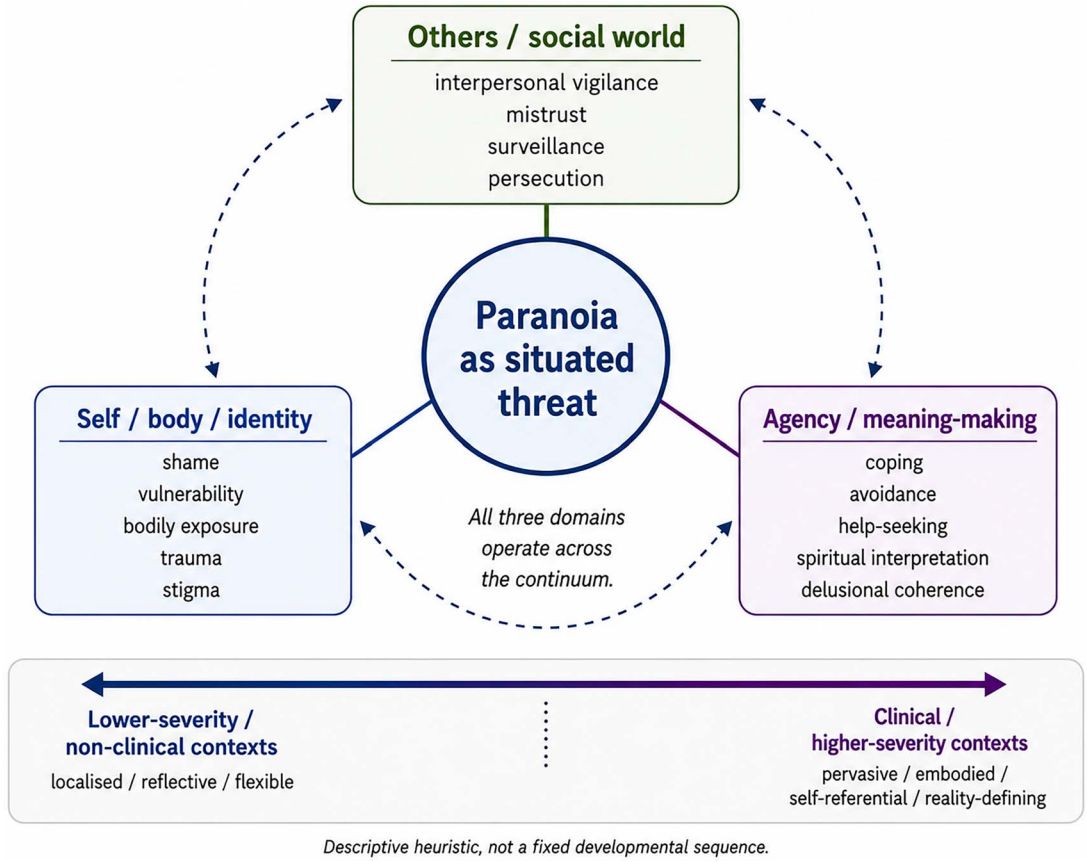


Figure 1. Integrative Model of the Lived Experience of Paranoia across the Continuum. The Figure Represents Paranoia as a Situated Transformation in the Relation between Self, Others, and World. The Three Domains—Others/Social World, Self/Body/Identity, and Agency/Meaning-Making—Are Intended as Dimensions that Operate across the Continuum, Not as Separate Severity Stages. Across Study Contexts, Paranoid Experience Ranged from more Localized, Reflective, and Flexible Forms to more Pervasive, Embodied, Self-Referential, and Reality-Defining Forms.

reasoning biases, negative self-beliefs, affective dysregulation, and safety behaviours.[1–3,59,60] However, qualitative evidence adds an important first-person perspective. In participants' accounts, mistrust was not only a cognitive appraisal, and avoidance was not only a maintaining behavior. These experiences often functioned as attempts to survive, protect the self, contain shame, reduce uncertainty, or impose coherence on a threatening world.[14,22,25,56] Thus, qualitative findings help clarify not only what paranoid beliefs are about, but also what they do for the person.

Our synthesis supports a dimensional view of paranoia. Quantitative and taxometric studies suggest that paranoid ideation and paranoid personality traits vary dimensionally across clinical and non-clinical populations.[3,5] Yet similar paranoid contents may differ in conviction, flexibility, self-reference, distress, functional impact, and embeddedness in broader changes of self and world-experience.[2] In lower-severity and non-clinical accounts, suspiciousness was more often localized, situation-bound, reflective, and negotiable.[43–45] In clinical and higher-severity accounts, paranoid threat became more pervasive, less flexible, more self-referential, and more closely tied to voices, external control, altered agency, embodiment, or changes in reality-experience.[9,22,29,51,55] We therefore interpret the continuum as a heuristic for examining both continuity and discontinuity, not as evidence of a necessary progression from everyday suspiciousness to persecutory delusion.

Our findings also converge with phenomenological and lived-experience approaches to psychosis, which argue that delusions are rarely isolated belief contents, but are embedded in broader alterations of selfhood, embodiment, affectivity, intersubjectivity, temporality, and world-experience.[8,9,13,21,61] We extend this perspective specifically to paranoia. Persecutory meanings were often intertwined with ideas of reference, voices, religious meanings, external control, bodily exposure, and altered agency.[50,51,53,54] This supports that paranoia should not be treated as a monothematic phenomenon, but as a persecutory configuration of broader alterations in meaning, agency, embodiment, and social relatedness.

We also found that paranoid meanings were frequently situated within biographical and social contexts. Trauma, bullying, neglect, abuse, racism, gendered threat, institutional coercion, poverty, stigma, and social exclusion appeared as

contexts in which mistrust and threat anticipation became personally meaningful.[6,16–18,49,56] This does not reduce clinical paranoia to realistic threat perception; rather, persecutory meanings may be shaped by the interaction between actual social injuries and psychotic processes. Clinical interpretation should therefore consider not only whether a belief is true or false, but also how threat is appraised, how flexible the interpretation remains, and how it relates to the person's history and social position. This is consistent with culturally sensitive, trauma-informed, and narrative-based approaches to psychosis, as well as with concerns about epistemic injustice in mental healthcare.[62] In this context, epistemic agency means allowing experiences of threat to be explored without being either uncritically validated or prematurely disqualified.

Our findings have clinical implications. Assessment should move beyond the presence, conviction, or bizarreness of persecutory beliefs. Clinicians should also ask what the belief or behavior is doing for the person: whether it protects, explains, contains shame, preserves dignity, restores agency, justifies withdrawal, or gives structure to overwhelming experience.[20,62] Therapeutic engagement should prioritize relational safety, transparency, collaboration, and attention to the person's explanatory framework, especially when help-seeking is shaped by mistrust, fear of coercion, previous invalidation, or the incorporation of services into the threat system.[24,57,63] In this sense, protecting epistemic agency is not separate from clinical care, but part of building the conditions in which paranoid experiences can be explored safely and meaningfully.

Future qualitative studies should include more non-clinical, subclinical, youth, culturally diverse, and early-stage populations, because the current evidence base remains weighted toward clinical psychosis-spectrum samples. Future work should compare clinical and non-clinical paranoid experiences without assuming either equivalence or categorical separation, examining conviction, distress, flexibility, self-reference, agency, embodiment, social context, and functional impact. Research should also avoid treating persecutory delusions as detached from broader psychotic experience, given their frequent co-occurrence with voices, referentiality, spiritual meanings, external control, and altered bodily or self-experience.[21,50]

This review has strengths. We provide an updated qualitative synthesis focused specifically on paranoia, suspiciousness, mistrust, and persecutory threat. We distinguished core from contextual evidence to preserve the centrality of paranoia-focused studies while incorporating relevant material from broader psychosis, trauma, stigma, embodiment, and recovery literatures. We also used a core-only evidence check to clarify which themes were robust across directly relevant studies and which should be interpreted as context dependent. However, we acknowledge limitations. We did not formally preregister the review protocol; the included studies were heterogeneous in population, setting, design, and analytic approach; and the evidence base was weighted toward clinical and high-income English-language contexts. We applied the continuum mapping at study level, so it should not be interpreted as a participant-level severity rating. Finally, some phenomenological dimensions may have been absent from primary studies because they were not specifically elicited or reported, rather than because they were not experienced by participants.

Conclusions

Paranoia is not only a belief about threat, but a lived transformation in the relation between self, others, and world. Across studies, paranoid experiences involved interpersonal danger, self-vulnerability, shame, embodied exposure, coping, and meaning-making. This supports a continuum view of paranoia, while showing that severity reflects not only intensity, but also changes in flexibility, agency, relational safety, and lived reality. Assessment and care should therefore move beyond the question of whether a paranoid belief is present. Clinicians should also ask what the belief means, what it does for the person, and how it is shaped by biography, social context, and lived experience. Such an approach may support more person-centered, recovery-oriented, and epistemically just mental healthcare.

Author Contributions

All authors had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Concept and design: A.M., M.B.M. Acquisition, analysis, or interpretation of data: A.M., M.B.M., G.A.D.B. Drafting of the manuscript: A.M., M.B.M.

Supplementary Material

Supplementary material is available at *Schizophrenia Bulletin Open* online.

Funding

Work supported by #NEXTGENERATIONEU (NGEU) and funded by the Ministry of University and Research (MUR), National Recovery and Resilience Plan (NRRP), project MNESYS (PE0000006) – A Multiscale integrated approach to the study of the nervous system in health and disease (DN. 1553 11.10.2022). This work was also supported by project EPIC, generously funded by a Wellcome Discovery Grant, "EPIC: Epistemic Injustice in Health Care" [226603/Z/22/Z].

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Data Availability

No new data were generated or analyzed in support of this research.

Data Access, Responsibility, and Analysis

A.M. and M.B.M.

References

1. Freeman D. Understanding and treating persecutory delusions. *Schizophr Bull*. 2024;50:233-235. https://doi.org/10.1093/schbul/sbae012
2. Freeman D, Garety PA. Comments on the content of persecutory delusions: does the definition need clarification? *Br J Clin Psychol*. 2000;39:407-414. https://doi.org/10.1348/014466500163400
3. Freeman D, Garety PA, Bebbington PE, et al. Psychological investigation of the structure of paranoia in a non-clinical population. *Br J Psychiatry*. 2005;186:427-435. https://doi.org/10.1192/bjp.186.5.427
4. Corlett P, Rossi-Goldthorpe R, Suthaharan P, Sheffield JM, de Obeso SC, Heyes C. Pseudosocial cognition and paranoia. *Trends Cogn Sci*. 2025;29:997-1006. https://doi.org/10.1016/j.tics.2025.05.019
5. van Os J, Reininghaus U. Psychosis as a transdiagnostic and extended phenotype in the general population. *World Psychiatry*. 2016;15:118-124. https://doi.org/10.1002/wps.20310
6. Campbell MLC, Morrison AP. The subjective experience of paranoia: comparing the experiences of patients with psychosis and individuals with no psychiatric history. *Clin Psychol Psychother*. 2007;14:63-77. https://doi.org/10.1002/cpp.510
7. Pienkos E, Sass L. Expressions of alienation: language and interpersonal experience in schizophrenia. *Journal of Psychopathology*. 2016;22:62-70.
8. Ritunnano R, Broome M, Stanghellini G. Charting new phenomenological paths for empirical research on delusions: embracing complexity, finding meaning. *JAMA Psychiatry*. 2021;78:1063-1064. https://doi.org/10.1001/jamapsychiatry.2021.1587
9. Ritunnano R, Littlemore J, Nelson B, Humpston CS, Broome MR. Delusion as embodied emotion: a qualitatively driven, multimethod study of first-episode psychosis in the UK. *Lancet Psychiatry*. 2026;13:125-139. https://doi.org/10.1016/S2215-0366(25)00341-4
10. Green H, Hauser L, Troyakov V. Are delusions beliefs? A qualitative examination of the doxastic features of delusions. *Psychosis*. 2018;10:319-328. https://doi.org/10.1080/17522439.2018.1528298
11. Bentall RP, Corcoran R, Howard R, Blackwood N, Kinderman P. Persecutory delusions: a review and theoretical integration. *Clin Psychol Rev*. 2001;21:1143-1192. https://doi.org/10.1016/S0272-7358(01)00106-4
12. Freeman D, Garety P. Advances in understanding and treating persecutory delusions: a review. *Soc Psychiatry Psychiatr Epidemiol*. 2014;49:1179-1189. https://doi.org/10.1007/s00127-014-0928-7
13. Belvederi Murri M, Catania S, Centra S, et al. The association between cannabis use and paranoia: meta-analysis of experimental and observational studies. *Neurosci Biobehav Rev*. 2025;176:106269. https://doi.org/10.1016/j.neubiorev.2025.106269
14. Bird JC, Freeman D, Waite F. The journey of adolescent paranoia: a qualitative study with patients attending child and adolescent mental health services. *Psychol Psychother*. 2022;95:508-524. https://doi.org/10.1111/papt.12385
15. Pastor-Cerezo V, Iborra CA. The echo of trauma: an interpretative phenomenological analysis of the impact of childhood sexual abuse on adult attachment and intimacy. *Eur J Trauma Dissociation*. 2026;10:100652. https://doi.org/10.1016/j.ejtd.2026.100652
16. Lazaridou FB, Schubert SJ, Ringeisen T, Kaminski J, Heinz A, Kluge U. Racism and psychosis: an umbrella review and qualitative analysis of the mental health consequences of racism. *Eur Arch Psychiatry Clin Neurosci*. 2023;273:1009-1022. https://doi.org/10.1007/s00406-022-01468-8
17. Gordon S, Mote J, Fulford D. Qualitative analysis of paranoia reported in clinical interviews with black and white adults with schizophrenia. *PS*. 2023;74:1263-1269. https://doi.org/10.1176/appi.ps.20220089
18. Ternamian AA, Marchal M, Haesebaert J, Haesebaert F. Positive symptoms and their associations with life and trauma events among young adults in a first-episode psychosis clinic: qualitative analysis. *BJPsych open*. 2025;11:e178. https://doi.org/10.1192/bjo.2025.10802
19. Ferrara M, Panzani A, Macis G, et al. Women and mental health: a gender-sensitive survey on determinants of health and care satisfaction in outpatient psychiatric services. *J Sex- Gend-Specif Med*. 2024;10:12-22.
20. Ritunnano R, Humpston C, Broome MR. Finding order within the disorder: a case study exploring the meaningfulness of delusions. *BJPsych Bull*. 2022;46:109-115. https://doi.org/10.1192/bjb.2020.151
21. Fusar-Poli P, Estradé A, Stanghellini G, et al. The lived experience of psychosis: a bottom-up review co-written by experts by experience and academics. *World Psychiatry*. 2022;21:168-188. https://doi.org/10.1002/wps.20959
22. Boyd T, Gumley A. An experiential perspective on persecutory paranoia: a grounded theory construction. *Psychol Psychother*. 2007;80:1-22. https://doi.org/10.1348/147608306X100536
23. Stopa L, Denton R, Wingfield M, Taylor KN. The fear of others: a qualitative analysis of interpersonal threat in social phobia and paranoia. *Behav Cogn Psychother*. 2013;41:188-209. https://doi.org/10.1017/S1352465812000422
24. Tully S, Wells A, Morrison AP. 'You've got your own demons that you've got to fight every day': a qualitative exploration of how people respond to the experience of psychosis. *Psychol Psychother*. 2017;90:550-566. https://doi.org/10.1111/papt.12124
25. Startup H, Pugh K, Cordwell J, Kingdon D, Freeman D. How do individuals with persecutory delusions bring worry to a close? An interpretive phenomenological analysis. *Behav Cogn Psychother*. 2015;43:465-477. https://doi.org/10.1017/S1352465813001136
26. Croce E, Simonelli G, Ferrara M, et al. Correlates of impaired timing abilities in schizophrenia: a systematic review. *J Nerv Ment Dis*. 2024;212:603-622. https://doi.org/10.1097/NMD.0000000000001810
27. Harper D, Thompson AR. *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners*1st edn. Wiley, 2011. https://doi.org/10.1002/9781119973249.
28. Smith JA, Larkin M, Flowers P. *Interpretative Phenomenological Analysis: Theory, Method and Research*. SAGE, 2008.
29. Fierro M, Hernández AM, Malcolm J. The psychopathology of delusion of control according to subjective experience. *Rev Colomb Psiquiatr*. 2018;47:221-228. https://doi.org/10.1016/j.rcp.2017.02.004
30. Green C, Garety PA, Freeman D, et al. Content and affect in persecutory delusions. *British J Clin Psychol*. 2006;45:561-577. https://doi.org/10.1348/014466506X98768
31. Jones A, Read J, Wood L. A retrospective case study of the thematic content of psychotic experiences in a first episode

psychosis population. *J Ment Health*. 2021;30:509-517. https://doi.org/10.1080/09638237.2020.1755024

32. Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. 2021;372:n71. https://doi.org/10.1136/bmj.n71
33. Tong A, Flemming K, McInnes E, Oliver S, Craig J. Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Med Res Methodol*. 2012;12:181. https://doi.org/10.1186/1471-2288-12-181
34. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med Res Methodol*. 2008;8:45. https://doi.org/10.1186/1471-2288-8-45
35. Critical Appraisal Skills Programme (2024). CASP (qualitative Checklist.) https://casp-uk.net/casp-checklists/CASP-checklist-qualitative-2024.pdf Accessed: 27/10/2024. Published online 2024. Accessed October 27, 2024. https://casp-uk.net/casp-checklists/CASP-checklist-qualitative-2024.pdf
36. Van Manen M. Phenomenology of practice. *Phenomenology & Practice*. 2007;1:11-30. https://doi.org/10.29173/pandpr19803
37. Dickson JM, Barsky J, Kinderman P, King D, Taylor PJ. Early relationships and paranoia: qualitative investigation of childhood experiences associated with the development of persecutory delusions. *Psychiatry Res*. 2016;238:40-45. https://doi.org/10.1016/j.psychres.2016.02.006
38. Fornells-Ambrojo M, Garety PA. Bad me paranoia in early psychosis: a relatively rare phenomenon. *Br J Clin Psychol*. 2005;44:521-528. https://doi.org/10.1348/014466505X35326
39. Lawlor C, Hall K, Ellett L. Paranoia in the therapeutic relationship in cognitive behavioural therapy for psychosis. *Behav Cogn Psychother*. 2015;43:490-501. https://doi.org/10.1017/S1352465814000071
40. Marshall E, Freeman D, Waite F. The experience of body image concerns in patients with persecutory delusions: 'people don't want to sit next to me. *Psychol Psychother*. 2020;93:639-655. https://doi.org/10.1111/papt.12246
41. Sher DA, Craythorne SL, Kabir T, Freeman D, Waite F. How do people recover from persecutory delusions? An interpretative phenomenological analysis. *Psychosis*. 2025;17:404-419. https://doi.org/10.1080/17522439.2025.2516469
42. Aggelidou K, Georgaca E. Effective strategies for coping with paranoid thoughts: a qualitative investigation. *Int J Ment Health*. 2017;46:188-205. https://doi.org/10.1080/00207411.2017.1304075
43. Allen-Crooks R, Ellett L. Naturalistic change in nonclinical paranoid experiences. *Behav Cogn Psychother*. 2014;42:634-639. https://doi.org/10.1017/S1352465813001148
44. Harper DJ, Timmons C. How is paranoia experienced in a student population? A qualitative study of students scoring highly on a paranoia measure. *Psychol Psychother*. 2021;94:101-118. https://doi.org/10.1111/papt.12250
45. Mosley DV, Owen KH, Rostosky SS, Reese RJ. Contextualizing behaviors associated with paranoia: perspectives of black men. *Psychol Men Masculinity*. 2017;18:165-175. https://doi.org/10.1037/men0000052
46. Canta GR, Miranda FL, Paixão R, Dias CA. Narcissistic equilibrium in paranoid schizophrenia. *Psychodyn Psychiatry*. 2019;47:373-401. https://doi.org/10.1521/pdps.2019.47.4.373
47. Dimaggio G, Catania D, Salvatore G, Carcione A, Nicolò G. Psychotherapy of paranoid personality disorder from the perspective of dialogical self theory. *Couns Psychol Q*. 2006;19:69-87. https://doi.org/10.1080/09515070600655122
48. Gooding P, Haddock G, Harris K, et al. The interplay between suicidal experiences, psychotic experiences and interpersonal relationships: a qualitative study. *BMC Psychiatry*. 2023;23:873. https://doi.org/10.1186/s12888-023-05164-2
49. Jones N, Rosen C, Kamens S, Shattell M. "It was definitely a sexual kind of sensation": sex, sexual identity, and gender in the phenomenology of psychosis. *Psychosis*. 2018;10:122-131. https://doi.org/10.1080/17522439.2018.1469036
50. Mohr S, Borras L, Betrisey C, Pierre-Yves B, Gilliéron C, Huguelet P. Delusions with religious content in patients with psychosis: how they interact with spiritual coping. *Psychiatry Interpers Biolog Processes*. 2010;73:158-172. https://doi.org/10.1521/psyc.2010.73.2.158
51. Morrison AP, Beck AT, Glentworth D, et al. Imagery and psychotic symptoms: a preliminary investigation. *Behav Res Ther*. 2002;40:1053-1062. https://doi.org/10.1016/S0005-7967(01)00128-0
52. Pratiwi A, Pujianto JS, Sukardi S, et al. Magical thinking and mystical experience: an exploration of delusional disorder in schizophrenic patients. *Iran J Nurs Midwifery Res*. 2025;30:641-645. https://doi.org/10.4103/ijnmr.ijnmr_18_23
53. Rhodes JE, Parrett NS, Mason OJ. A qualitative study of refugees with psychotic symptoms. *Psychosis*. 2016;8:1-11. https://doi.org/10.1080/17522439.2015.1045547
54. Rhodes JE, Healey LJ. 'Many die in the hurricane': an interpretative phenomenological analysis of adults with psychosis and a history of childhood physical abuse. *Clin Psychol Psychother*. 2017;24:737-746. https://doi.org/10.1002/cpp.2043
55. Pietkiewicz IJ, Kłosińska U, Tomalski R. Delusions of possession and religious coping in schizophrenia: a qualitative study of four cases. *Front Psychol*. 2021;12:628925. https://doi.org/10.3389/fpsyg.2021.628925
56. Franco L, Nicholls L. Does madness really exist? An autobiographical analysis of psychosis as a response to trauma and not a 'mad' state of mind. *Aporia*. 2023;15:19-28. https://doi.org/10.18192/aporia.v15i1.6587
57. Drinnan A, Lavender T. Deconstructing delusions: a qualitative study examining the relationship between religious beliefs and religious delusions. *Ment Health Relig Cult*. 2006;9:317-331. https://doi.org/10.1080/13694670500071711
58. Coughlan H, Humphries N, Clarke MC, Healy C, Cannon M. Psychotic-like experiences? Trajectories and typologies of hallucinations and delusions from early adolescence to early adulthood in a population-based sample of Irish youth. *Ir J Psychol Med*. 2022;39:207-222. https://doi.org/10.1017/ipm.2021.31
59. Garety PA, Freeman D, Jolley S, et al. Reasoning, emotions, and delusional conviction in psychosis. *J Abnorm Psychol*. 2005;114:373-384. https://doi.org/10.1037/0021-843X.114.3.373
60. Freeman D, Loe BS. Explaining paranoia: cognitive and social processes in the occurrence of extreme mistrust. *BMJ Ment Health*. 2023;26:e300880. https://doi.org/10.1136/bmjment-2023-300880
61. Sass LA, Parnas J. Schizophrenia, consciousness, and the self. *Schizophr Bull*. 2003;29:427-444. https://doi.org/10.1093/oxfordjournals.schbul.a007017
62. Bortolotti L. The epistemic innocence of motivated delusions. *Conscious Cogn*. 2015;33:490-499. https://doi.org/10.1016/j.concog.2014.10.005
63. Saayman N. The feared therapist: on being part of the psychotic patient's paranoid delusion. *Br J Psychother*. 2021;37:36-51. https://doi.org/10.1111/bjp.12608

© The Author(s) 2026. Published by Oxford University Press on behalf of the University of Maryland's school of medicine, Maryland Psychiatric Research Center. This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial License (https://creativecommons.org/licenses/by-nc/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited. For commercial re-use, please contact reprints@oup.com for reprints and translation rights for reprints. All other permissions can be obtained through our RightsLink service via the Permissions link on the article page on our site—for further information please contact journals.permissions@oup.com.
Schizophrenia Bulletin Open
https://doi.org/10.1093/schizbullopen/sgag027
Major Review (Orig)