

Qualitative Analysis of Paranoia Reported in Clinical Interviews With Black and White Adults With Schizophrenia

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Black adults in the United States are more likely to be diagnosed as having schizophrenia spectrum disorders and to report experiences of paranoia than are White adults. Cultural mistrust, or marginalized groups' adaptive skepticism toward dominant historically White institutions, is associated with paranoia among Black individuals, suggesting that experiences of paranoia may be culturally mediated. The authors aimed to explore thematic differences between Black and White adults with schizophrenia spectrum disorders in their experiences of paranoia, including potential differences in persecutory content, cultural mistrust, and related themes. The authors conducted a thematic content analysis of archival qualitative

data on experiences of paranoia reported by Black and White adults with schizophrenia spectrum disorders (N=21) in a structured clinical interview. Distinct themes related to cultural mistrust and persecutory paranoia emerged among the participants, suggesting that lived experiences of persecution and discrimination may affect how Black adults with schizophrenia spectrum disorders interpret threat and express paranoia. These findings highlight the importance of culturally responsive approaches in assessment and conceptualization of clinical paranoia versus cultural mistrust.

Psychiatric Services in Advance (doi: 10.1176/appi.ps.20220089)

Black adults in the United States are two to three times more likely to be diagnosed as having schizophrenia spectrum disorders than are White adults (1–3). Regardless of differences in clinician-perceived severity of psychosis symptoms, clinicians are more likely to diagnose schizophrenia among Black patients than among White patients, suggesting a racial bias (3). Many diagnostic instruments are normed on White populations, leading to skewed representations of how baseline or normative symptoms may present for Black individuals with schizophrenia spectrum disorders (4).

Paranoia is a mode of thinking characterized by feelings of suspicion, ill will, resentment, or beliefs in external control or influence that are not supported by objective evidence (5). Paranoid delusions are often further characterized as persecutory beliefs (i.e., false beliefs that someone or a group of others intends harm) or as delusions of reference (i.e., false beliefs that one is being observed without one's consent) (6). Paranoia is a primary feature of psychosis and may be susceptible to racial bias in assessments (7, 8). Researchers have argued that the shift in emphasis on paranoia as a major criterion for schizophrenia in the United States was purposively weaponized against Black communities during the civil rights era, leading to an increase in Black men in particular receiving schizophrenia spectrum

disorder diagnoses (2). Some experiences of paranoia, such as bizarre delusions that could not objectively occur in reality (e.g., the belief that aliens are monitoring one's thoughts), may be unanimously accepted as part of a clinical syndrome; however, many others (e.g., the belief that one is being followed or monitored) are ambiguous, and their classification therefore relies on the judgment of the

HIGHLIGHTS

- Black adults in the United States are more likely to be diagnosed as having schizophrenia spectrum disorders and to report experiences of paranoia than are White adults.
- Lived experiences of racism and persecution may affect how Black adults interpret threat and express paranoia in clinical contexts.
- Thematic differences in reports of expressed paranoia (i.e., persecutory content and cultural mistrust) were identified among Black and White adults to explore the implications of cultural context in phenomenological experiences of paranoia.

assessor. The more ambiguous a potential experience of paranoia, the more susceptible it may be to assessor bias.

Racial bias is likely not the only factor in understanding differences in experiences of paranoia between Black and White communities. Race-related environmental stressors (e.g., structural racism) may increase the likelihood of experiencing psychosis, influencing developmental pathways of psychosis in several ways (9). Additionally, researchers have argued that experiences of racial trauma and oppression may foster normative and even adaptive increases in levels of subclinical paranoia among Black people (7, 10). For example, Iacovino and colleagues (8) reported that lower socioeconomic status and a history of childhood trauma were associated with more severe paranoia among Black, but not White, individuals. Rather than solely capturing experiences that impair functioning among Black individuals, paranoia assessments may instead be measuring responses of cultural mistrust, defined as the adaptive skepticism or mistrust by people of color toward White people and historically oppressive institutions (11). Perceived racism among Black populations has been shown to be correlated with measures of cultural mistrust (12). When assessed among Black individuals, cultural mistrust is associated with traditional clinical assessments of paranoia and a higher likelihood of receiving a diagnosis of paranoid schizophrenia (13, 14).

Cultural implications in expressions of paranoia among Black adults with schizophrenia spectrum disorders is an understudied area. Quantitative measures of paranoia (e.g., the Paranoid Thoughts Scale [6]) and cultural mistrust (e.g., the Cultural Mistrust Inventory [15]) have strengths but are limited in their ability to assess detailed, individualized content. A thorough analysis of the content of paranoia experiences reported by Black adults with schizophrenia spectrum disorders in the United States, particularly in the context of formal clinical assessment, may help clinicians better differentiate potentially adaptive or nonpathological responses (e.g., cultural mistrust) from pathological content, thereby preventing overpathologizing of normative experiences for this population.

In this study, we conducted a post hoc qualitative analysis examining the content of paranoia experiences, as reported by Black and White adults with schizophrenia spectrum disorders during a structured clinical interview assessing psychotic symptoms. We conducted an exploratory thematic content analysis from a sample of responses to the Brief Psychiatric Rating Scale (BPRS) (16), a structured clinical interview that assesses psychosis symptoms from community-dwelling outpatient adults with schizophrenia or schizoaffective disorder. First, we differentiated between persecutory and reference experiences. Next, we identified potential themes stemming from cultural mistrust (e.g., fear of being targeted), racialized experiences (e.g., discussion of racial-ethnic background of oneself or others), and other relevant topics (e.g., acknowledgment that experiences of paranoia may be linked with mental health status). We

focused on thematic differences in paranoia between Black and White participants, including differences in persecutory content, cultural mistrust, and related themes. We note that this analysis was conducted retrospectively, and data were therefore not collected with an intentional framework for assessing cultural mistrust. The aim of this study was to provide a nuanced presentation of the impact of cultural context on phenomenological experiences of paranoia.

METHODS

Archival interviews using the BPRS (N=21) from several published (17, 18) and unpublished institutional review board–approved studies were transcribed and verified by two authors (S.G., J.M.). We identified reported experiences of paranoia for each participant. The data were then coded on two levels: first for type of paranoia (reference or persecutory) and second for thematic content analysis based on a priori codes outlined by the authors to capture themes related to cultural identity and cultural mistrust.

Population

Archival interview data from 21 participants with schizophrenia or schizoaffective disorder were analyzed. Participants were community-dwelling outpatients who had been enrolled in one of three research studies conducted between 2017 and 2020 (before the COVID-19 pandemic). Most participants (N=19) were originally recruited for a mobile health open trial (17, 18). The remaining two participants were recruited for presently unpublished studies, including a group treatment open trial (N=1) and a study assessing pain perception (N=1). Psychiatric diagnoses were previously confirmed through either chart diagnosis from a treatment provider or a Structured Clinical Interview for DSM-5 (19) at the time of original study participation. Only participants who identified as non-Hispanic White (N=12) or Black (N=9) and who previously gave consent to a recording of their clinical interview on psychiatric symptoms were included in this study.

Interviews

Participants were originally interviewed by clinical psychology graduate or postdoctoral trainees, master's level or higher, with different racial-ethnic backgrounds (identifying as East Asian, South Asian, or non-Hispanic White) between 2017 and 2020. Interviews took place in California or Massachusetts.

Experiences of paranoia were evaluated from responses to the BPRS (16). The BPRS is a structured, clinician-rated interview for evaluating psychiatric symptoms among individuals with a schizophrenia spectrum disorder. Assessment of positive symptoms includes interview questions on somatic concern, grandiosity, suspiciousness, unusual thought content, hallucinations, bizarre behavior, and disorientation. Assessment pertaining to BPRS-defined suspiciousness includes questions about thoughts of reference and

TABLE 1. Demographic and clinical characteristics of adults with schizophrenia spectrum disorders included in this study, by race (N=21)

Characteristic	White (N=12)		Black (N=9)		Test statistic	df	p ^a
	N	%	N	%			
Male	9	75	4	44	$\chi^2=2.04$	1	.15
Schizophrenia	4	33	7	78	$\chi^2=4.07$	1	.04
White interviewer	3	25	4	44	$\chi^2=.88$	1	.35
Age (M \pm SD years) ^b	45.8 \pm 8.6		49.1 \pm 10.2		t=.63	19	.42

^a p values were estimated with chi-square or independent-samples t tests.

^b Range: White, 29–57 years; Black, 35–60 years.

persecution related to clinical paranoia. Interviews assessed symptoms from the previous 2 weeks.

Data Preparation and Analysis Procedures

Members of the research team transcribed available prerecorded (audio or video) BPRS interviews from participants in previous research studies who had consented to interview recording and for whom accompanying demographic information was available. Identifying information (such as specific names, locations, and addresses) was removed from the transcripts before analysis. The coders (S.G., J.M.) were not blind to participants' race or gender identity. Analysis memos were documented for each of the interviews to capture paranoia content (20). Paranoia was defined as an experience consistent with either a potential delusion of reference or a persecutory delusion (6).

Coding procedures for thematic content analysis were implemented to identify different themes of paranoia across the sample (21). The primary coding procedure comprised two levels. The first level involved line-by-line identification of all potential experiences of paranoia for each participant. Each experience was individually coded as either a potential delusion of reference or a persecutory delusion (i.e., mutually exclusive codes). Responses that involved potential cultural themes in response to paranoia content but did not meet criteria for either reference or persecutory paranoia content were separately coded. Participants who reported no paranoia content were removed from the qualitative analysis.

After the first level of coding by paranoia category, the same reported experiences of paranoia were then coded on the basis of a priori categories defined by the study authors (S.G., J.M.) to capture relevant cultural themes. These codes included, but were not limited to, reference to one's race or the racial background of another person; the location of a specific paranoia-related event (public vs. private); persecutory content, directed at a specific person or not; reference to racial politics (e.g., discourse related to race in political and sociocultural contexts) (22); community violence; and mental health status. (A full list of a priori codes is available from the authors on request.) These codes were not mutually exclusive because they aimed to capture a range of relevant contextual themes related to cultural mistrust (23). This qualitative coding process enabled identifying potential

differences in content and themes that arose when Black and White participants discussed experiences of paranoia. Non-mutually exclusive codes that were found to be irrelevant or rare (e.g., no participant reported reference to community violence) were removed by author consensus (S.G., J.M.). Three remaining codes were then examined and assessed in detail.

Final synthesis involved quantifying the total number of experiences of reference and persecution paranoia and further examining the non-mutually exclusive codes. The same study authors who completed the first level of coding collaborated to create a database summarizing each coded experience of paranoia (reference or persecutory content) for all participants. We then analyzed the non-mutually exclusive codes, along with a summary of each coded paranoia event, and identified primary keywords and themes of each event. Two authors (S.G., J.M.) met to discuss the key themes that emerged from their individual analyses until consensus was reached, and further coding was conducted if necessary (e.g., whether paranoia content was directed at a friend, relative, or other specific type of person and whether the participant's experience was likely or unlikely to be delusional). The authors also discussed and agreed on exemplary quotations from participants for the various themes that arose during the analysis.

RESULTS

Participants' ages ranged from 29 to 60 years. The two racial groups (i.e., White and Black) did not significantly differ in the proportion of men or mean age (Table 1). We also examined whether White and Black participants differed in terms of how many were interviewed by a White or a non-White interviewer (Tables 1 and 2) and observed no statistically significant differences. A significantly higher proportion of participants with a schizophrenia (vs. schizoaffective disorder) diagnosis identified as Black, versus White ($\chi^2=4.07$, $df=1$, $p=0.04$).

Participants Reporting Paranoia Content

Nine of the 12 White participants (75%) and eight of the nine Black participants (89%) reported paranoia content during their BPRS interviews. (Table 2 shows the demographic characteristics of this subgroup; these characteristics did not significantly differ between White and Black participants.) The proportion of participants who reported paranoia content did not significantly differ between men and women. Of the 17 participants who reported paranoia content, Black and White participants did not significantly differ in the proportion of male participants, having a White versus non-White interviewer, schizophrenia diagnosis, or mean age.

TABLE 2. Demographic characteristics of study participants who reported paranoia content, by race (N=17)

Characteristic	White (N=9)		Black (N=8)		Test statistic	df	p ^a
	N	%	N	%			
Male	6	67	4	50	$\chi^2=.49$	1	.49
Schizophrenia	3	33	6	75	$\chi^2=2.95$	1	.09
White interviewer	3	33	3	38	$\chi^2=.03$	1	.86
Age (M±SD years) ^b	49.2±8.8		49.3±10.7		t=.93	15	.37

^a p values were estimated with chi-square or independent-samples t tests.

^b Range: White, 29–55 years; Black, 35–60 years.

Themes

Each experience of paranoia was individually coded as either a potential delusion of reference or a persecutory delusion. Coding for cultural themes that arose when Black and White participants discussed experiences of paranoia resulted in three non-mutually exclusive categories—paranoia directed at specific others, paranoia related to mental illness, and cultural mistrust—which we examined in detail (Table 3).

Delusions of reference versus persecution. Participants reported a mixture of reference and persecutory contents. The phenomenological experiences of paranoia reported by Black participants elicited distinct themes related to safety and danger. For example, some Black participants reported feeling targeted by authority figures. Others expressed that they felt that their safety was threatened or at stake in some way (Table 4). This finding may suggest that lived experiences of Black participants distinctly influenced the types of paranoia the participants expressed.

Seven of the eight Black participants (88%) and four of the nine White participants (44%) reported persecutory content. One participant, a Black woman, reported paranoia content that was exclusively persecutory. She discussed instances over the past 2 weeks where she had fleeting ideas that others might be “out to get her” or that she was in danger. For example, when asked whether she ever felt that people might be talking about her, she responded,

Participant: I feel like when they do that, it’s a jealousy issue. . . . And again, they could know me, but I don’t know them.

Interviewer: What do you think they might be saying?

Participant: Bad stuff of course. Maybe something like, “Oh, she thinks she’s better than everybody,” and, “Let’s get her” or, you know, some things like that.

She also discussed separate instances that felt “very real” when unknown people on the train or on the street were staring at her. When asked, “Have you felt like you were in any danger?” she responded,

I don’t know, I just felt like . . . a gang of people in a way whispering behind my back, and then they’re looking at me, you know, like, with this evil look in their eyes, and . . . it’s really, really scary, which I know now it’s not real most of the time, but it . . . seems like it is at that time when you’re noticing that.

She then described that these thoughts were difficult to get out of her mind, but that, to feel better, she takes deep breaths and tells herself, “Don’t be afraid and just keep right on going and then just defend yourself. If something happens, you defend yourself.” However, she noted that she did not need to “defend herself” in any actionable way when these thoughts occurred.

Paranoia directed at others. Both Black (N=5 of 8, 63%) and White (N=6 of 9, 67%) participants mentioned a specific person or group of people (e.g., a friend or neighbors) when discussing potential paranoia content (Table 4). Both groups discussed interpersonal instances that objectively could have occurred, and only two White participants discussed instances that were clearly delusional (i.e., bizarre): one White participant, a man, reported the belief that his mother could both read his thoughts and put thoughts into his head, and another White man reported the belief that the Illuminati were attempting to recruit him. Black participants discussed distrusting neighbors, residential home or shelter cohabitants and staff, and, in one case, a property manager. In all instances, these participants’ responses were insufficient to ascertain whether the experience was delusional.

Paranoia related to mental illness. Both Black (N=2 of 8, 25%) and White (N=5 of 9, 56%) participants explicitly and spontaneously described their experiences of paranoia as related to their psychiatric diagnosis. For example, one participant, a Black man, responded that he thought that other people take special notice of him or watch him and said, “Yeah, I get paranoid, yeah.” A White woman discussed the experience of believing strangers were saying critical things about her. When asked for more details about this experience, she reported that she had told her therapist about these experiences, and when asked whether these experiences affected her life or her self-esteem, she replied, “Yeah, I mean . . . I’d be delighted if I weren’t burdened by symptoms.”

Cultural mistrust and related content. References to themes of cultural mistrust were rare. When they did arise for Black participants, they involved subtle acknowledgments of the participant’s visible racial identity or discussions about their sociopolitical context that was deemed threatening or unfair. One participant, a Black woman, discussed then-President Donald Trump’s comments on social media when she was asked, “Have you felt like you were in any danger in the past 2 weeks?”

Just hearing, like, a lot of the things in the news kind of makes me feel . . . like maybe the president’s gonna start a war on Twitter, and then, like, people are going to start coming over here and killing people, but, like, I mean that’s legitimate what I was thinking, but I mean, like, as time goes on, . . .

TABLE 3. Description of non-mutually exclusive themes related to experiences of paranoia and cultural context

Code	Description	Example quotation
Paranoia directed at specific others	Participant expresses paranoia as being directed toward a specific person or group of people (e.g., neighbors).	"So I think sometimes they be watching me, but it's only, like, one person, you know. . . . We only have one staff, so it's, like, that one person. . . ."
Experience of paranoia related to mental illness	Participant references mental illness as possible cause of paranoia experience or notes that a particular experience may be a delusion.	"Maybe it's just my paranoid delusions, but sometimes it feels that way."
Cultural mistrust	Participant refers to their own or another person's race or racial identity or refers to cultural or political content.	"Last night, I was walking up to the store, and a group of kids in their 20s were driving by, White kids."

I'm kind of . . . not really focusing on my thoughts [on that danger].

The participant's self-assurance that "that's legitimate what I was thinking" implied an understanding that her thoughts related to the former president might be viewed as unrealistic, although she disagreed with that understanding. This participant's beliefs were in line with other Black adults' mistrust of the former president at the time (24) and apprehension about his numerous recorded instances of using social media to antagonize political leaders (22).

The same participant also discussed governmental control in her life related to practices of racial and cultural discrimination—although raising this topic is not necessarily indicative of paranoia. When asked, "Have you felt like you were under the control of another person or force?" she responded,

I mean, the government, you know? . . . Yeah, there's a lot of control that I feel affects my life. Like, where I can work and live and stuff like that. So an example would be, I wanted to go to school . . . close to my house when I was in high school, but, like, the way it was zoned was [that] I had to go to a school . . . 20 minutes away instead of the one that was 10 minutes away, so [it didn't make any sense].

Another participant, a Black man, made a more implicit reference to his race when he responded to the question, "Does it seem like other people are taking special notice of you or watching you?"

Participant: Sometimes.

Interviewer: Can you tell me why they might be doing that?

Participant: Um, trends, trends, I guess. Just common thought.

Interviewer: Trends in what?

Participant: Um, cultural. Sometimes.

The only participant who explicitly referenced race was a White man, who discussed feelings of being noticed or monitored in public:

Down the street from my house when I'm going to the stores sometimes. . . . Like, last night I was walking up to the store, and a group of kids in their 20s were driving by, White kids, and a kid in the passenger seat rolled down the window and yelled out the window and goes, "What the [expletive] is that? What the [expletive] is that? Ha ha ha." He's laughing at me, making . . . strange faces at me.

Of note, this participant explicitly described the people who were making fun of him as White, the same race as him, to a White female interviewer.

DISCUSSION AND CONCLUSIONS

Exploratory thematic content analysis frameworks were applied to participants' responses to a structured clinical interview (i.e., the BPRS) to examine experiences of paranoia among Black and White adults with a schizophrenia spectrum disorder. Qualitative, narrative content was used to identify themes stemming from cultural mistrust and racialized experiences. In total, 81% (N=17) of the participants reported paranoia content in their interviews. Among these participants, the proportion of reported paranoia experiences did not significantly differ by race or other demographic factors.

Salient themes emerged in exploring how participants reported and described experiences of paranoia. One notable theme was that Black participants regularly reported distrust, skepticism, or oppressive experiences (e.g., a property manager treating them unfairly). Spontaneous references to themes of cultural mistrust were rare. However, when they arose, Black participants discussed their perspectives and feelings about sociopolitical and governmental influence on livelihood and safety as well as their awareness of social visibility as a person of color. These experiences suggest that systemic racism may inform and affect lived experiences of paranoia.

These findings are relevant in considering how experiences of paranoia may be culturally mediated. This study surpassed the traditional constraints of paranoia assessment (such as paranoia frequency or severity) and examined the qualitative nature of reported experiences of paranoia content. This study contributes to the qualitative literature exploring how Black and White people with schizophrenia spectrum disorder may understand, express, and experience paranoia contextually. Within the context of a clinical interview meant to assess symptoms of psychosis for a person with a diagnosed schizophrenia spectrum disorder, the experience of being stared at by neighbors or distrust of a medical professional may be classified as resulting from mental illness. However, experiences for which it is unclear whether they are based on delusional content (e.g., a clinician potentially misinterpreting as delusional a patient's real experience of an adverse encounter or

TABLE 4. Summary of potential paranoia content in reference to specific others

Participant race and sex	Content summary
Black woman	Concerned that neighbors are talking about her behind her back
Black woman	Believed that a residential home staff member singles her out and points out things she does wrong more often than do other residents; concerned about her safety around a specific resident cohabitant
Black woman	Felt like property manager gives her a harder time and takes longer with paperwork than with other residents; worried about getting into a verbal altercation with a woman at a shelter she frequents
Black man	Concerned about group home cohabitants "messing" with food he eats in the group home (e.g., only buying food he does not eat)
Black man	Had desire to avoid church because of concerns that church members would perceive him as different from how he used to be
White woman	Noted specific instances of feeling distrustful of two different men who she believed were trying to sell her drugs or engage her in prostitution
White woman	Wondered whether her pharmacologist could see her private calendar when setting up her next appointment
White man	Concerned about a neighbor whom he believes to have a history of violence; discussed incident of a car full of people yelling and laughing at him on the street; believed that his mother can read and put thoughts into his mind
White man	Believed Illuminati members would follow him in cars and would try to recruit him
White man	Reported feeling uncomfortable answering interviewer's questions
White man	Concerned about some friends' intentions toward him

discrimination) may perpetuate the pathologizing of normative and potentially protective beliefs and experiences among Black adults. Additionally, clinical paranoia in historically oppressed communities may be due to lived experiences of discrimination. Even when the paranoia content is delusional in nature, themes of persecution may be more prevalent among such groups because of lived experiences of oppression. Further research is necessary to explore nuances of normative and pathological experiences of paranoia among Black patients and other marginalized groups. Future studies may contribute to the enhancement of knowledge around intersections of lived experiences of persecution and paranoia.

Because we used archival data for this analysis, we could not ask follow-up questions, nor could we include measures related to cultural mistrust or other cultural assessments. This study did not have an intentional framework for eliciting participant responses related to cultural mistrust, which may have resulted in an underestimation of cultural mistrust related to paranoia in our sample. Despite these limitations, it was evident that Black participants' expressions of paranoia highlighted distinct themes related to social positionality. Although preliminary, these findings may offer a useful entry point for considering the role of culture and cultural mistrust in mediating experiences of paranoia among individuals from historically oppressed groups. Future research should include culturally informed methods of assessment and evaluation (i.e., interview questions directly probing for content about cultural mistrust and highlighting contextual factors that may influence experiences of paranoia). These efforts could support in-depth reflections about how aspects of identity and experiences of racial persecution may play a role in experiences of paranoia.

In future studies, researchers and clinicians may also wish to more explicitly acknowledge how systems of oppression may influence a person's life, symptoms, and previous psychiatric care. Additionally, it may be integral to assess collateral sources (e.g., family members) in making clinical and diagnostic decisions (e.g.,

identifying delusional thought content), particularly for members of marginalized communities. Future research in this area may aim to better assess participants' psychosocial contexts and to explore frameworks of cultural humility in training professionals who make clinical determinations. In considering contextual implications of paranoia, providers can more effectively help patients feel heard and validated, regardless of whether their experiences are delusional. This approach, in turn, may help clinicians be more intentional about examining their own biases and approaching clients from a culturally responsive perspective. The construction of a culturally appropriate assessment of paranoia may help researchers and clinicians contextualize lived experiences of persecution and differentiate normative feelings of distrust from clinical paranoia.

Our findings should be considered preliminary. This study used a post hoc analysis with a small convenience sample. Spontaneous responses related to themes of cultural mistrust or racial identity were rare in our sample, limiting the scope of our analysis. All studies included in this analysis used samples exclusively comprising people with a diagnosis of schizophrenia or schizoaffective disorder; thus, all interviewers were aware of participants' preexisting diagnoses and were potentially influenced by this knowledge. Although structured clinical interviews were used to confirm diagnoses for most participants, it is important to acknowledge pervasive misdiagnosis of Black individuals due to racial bias. The BPRS interview captures only some aspects of clinical paranoia from the past 2 weeks among individuals with a schizophrenia spectrum disorder. In future studies, researchers may wish to include a more comprehensive lifetime assessment of paranoia experiences alongside an assessment of cultural mistrust, or of other related constructs, to better capture the relationship between paranoia and cultural mistrust among individuals with schizophrenia spectrum disorders.

Additionally, we examined only two racial groups; understanding the intersections of cultural mistrust and paranoia in

non-Black racial-ethnic minority populations and other marginalized groups with serious mental illness is an important inquiry for future research. Finally, the lack of Black interviewers was a major limitation of our study. Some evidence suggests that the racial identity of clinicians may play a role in the diagnosis of Black adults with schizophrenia spectrum disorders (25). It is important that future research include Black interviewers and clinicians, while also acknowledging the structural barriers that prevent Black-identifying people from occupying these positions in academia and health care settings. Researchers must be intentional in conducting research examining issues related to systemic racism.

This study was a preliminary investigation into phenomenological experiences of paranoia among adults with schizophrenia spectrum disorders. The results suggest that the qualitative nature of persecutory experiences and cultural mistrust may differ among racial groups. These findings speak to the importance of understanding how discrimination and systemic racism inform the narratives and experiences of Black individuals with schizophrenia spectrum disorders. Continued assessment of racial trauma and cultural mistrust related to paranoia may contribute to further development and implementation of culturally responsive interventions for diverse populations with schizophrenia spectrum disorders. Understanding the divergences between clinical paranoia and cultural mistrust is one aspect of a greater push toward addressing issues of access and equity in clinical research and practice. Multicultural frameworks and responsive treatment are key in supporting and improving the quality of life for Black adults with serious mental illness.

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This work was funded in part by NIMH (grant R21 MH-111501-01 to Dr. Fulford). The authors thank Kathy Vong, B.A., for assisting with audio transcription.

Dr. Fulford reports receiving consultant fees from Boehringer Ingelheim, Click Therapeutics, and KHealth. The other authors report no financial relationships with commercial interests.

Received February 17, 2022; final revision received March 19, 2023; accepted March 24, 2023; published online May 31, 2023.

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