Brit. J. Psychiat. (1982), 141, 344–349

Paranoia Revisited

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Summary: The modern conceptualization of paranoia depends largely on the work of Emil Kraepelin. After him, German psychiatry concentrated on detailed descriptions of psychopathology in paranoid states, but there were few diagnostic or therapeutic advances till lately. A revival of interest is apparent, but this may be stultified by inaccurate criteria for paranoid disorders in DSM III, whose influence, at least in North America, appears assured for a considerable time.

The ICD 9 classificatory system (1978) defines paranoia (297.1) as 'a rare chronic psychosis in which logically constructed systematized delusions have developed gradually without concomitant hallucinations or the schizophrenic type of disordered thinking. The delusions are mostly of grandeur . . . , persecution or somatic abnormality'. The ICD 9 makes no comment about causation, whereas Kraepelin, influenced by contemporary French views (Hoenig, 1981) proposed that paranoia arose from 'understandable' personality features. Both describe paranoia as an encapsulated, monosymptomatic psychosis.

DSM III's definition (American Psychiatric Association, 1980) is similar, but one diagnostic criterion insists on 'a chronic and stable persecutory delusional system of at least six months' duration'. Fish (1974) pointed out that English-speaking psychiatrists often err in equating 'paranoia' with 'persecution' or 'angry suspiciousness', whereas it simply denotes a delusional state. Kendler (1980a) has argued cogently that DSM III's insistence on a specific delusional content is of questionable validity.

The subtypes of paranoia

The definitive article on the history of paranoia is that by Lewis (1970), who notes that Kahlbaum (1863) presaged its modern description by Kraepelin. The latter, who observed a mere 19 cases (Fried and Agassi, 1976), regarded paranoia as a distinct illness, and did not insist on persecutory ideas or delusions. He described three subtypes (Day and Semrad, 1978); these were *erotomania* (de Clérambault, 1942; Seeman, 1978; Lovett Doust and Christie, 1978; Enoch and Trethowan, 1979), *paranoid jealousy* (Enoch and Trethowan, 1979; Seeman, 1979), and *megalomania*. Kraepelin also mentioned a possible hypochondriacal form, but did not himself see a convincing case of this type, which is now known as *monosymptomatic hypochondriacal psychosis* (MHP), and which does appear to be a subtype of paranoia. Megalomanic paranoia remains a shadowy concept, though grandiosity is a common background factor in paranoia (Swanson *et al*, 1970). On the other hand, erotomania, paranoid jealousy and MHP are well-documented, and apparently not nearly so rare as alleged.

Anger and querulance are common in paranoia (Munro, 1980) and Sim (1981) describes 'litigious paranoia', in which individuals angrily pursue an unreasonable and unending quest for restitution. Winokur (1977) includes litigious cases within paranoid illness (which he renames 'delusional disorder') along with hypochondriacal, erotic, grandiose and persecutory forms.

The diagnosis of paranoia in clinical practice

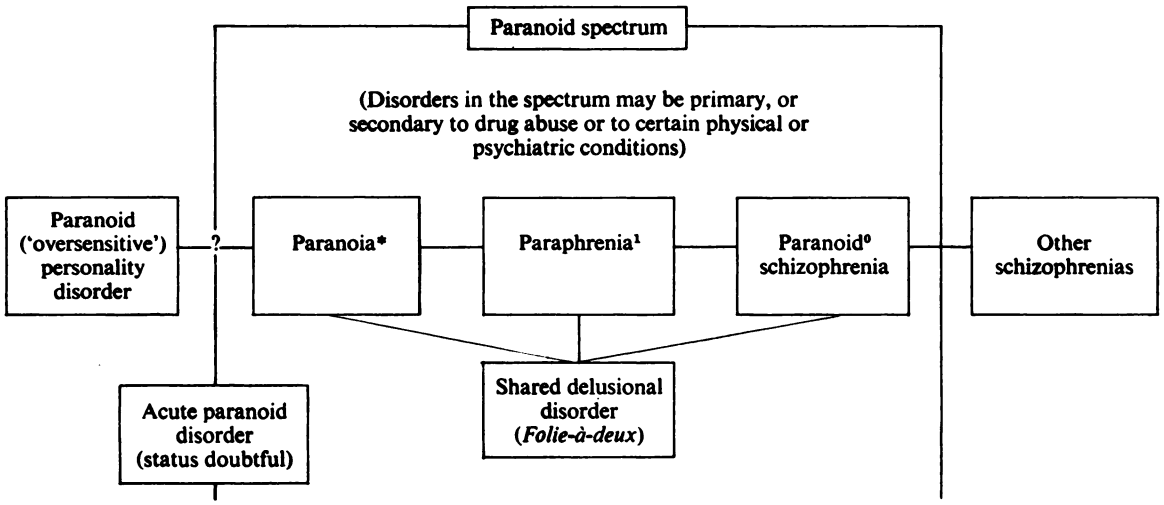
Kraepelin's views on paranoia were considerably disputed (Fish, 1962), and some of his diagnoses called in question by Kolle (1931). Authorities insisted on the excessive rarity of 'paranoia vera' (Kolle, 1957), and some declared the illness did not exist at all (Gregory and Smeltzer, 1977). More recently, Slater and Roth (1969) allowed the existence of paranoia and enumerated varieties with delusions of persecution, jealousy, grandeur, disfigurement or of emitting an odour. Recent evidence supports paranoia as an acceptable diagnosis (Johanson, 1964; Kendler, 1980b), yet the *British Medical Journal* (Leading Article, 1980) said that 'Paranoia is no longer a fashionable term'. The following reasons are suggested for this controversy:

1. Kraepelin's few cases and the doubt later cast on them have left a shadow.
2. It is often forgotten that erotomania, pathological jealousy, MHP, megalomania and litigiousness can be included in the diagnosis of paranoia, as well as delusions of persecution. When considered as separate entities, this fragments the overall concept of paranoia.

3. The smallness of case-series may be misleading and MHP recently proves to be much commoner than appreciated (Munro, 1980).
4. The literature is careless in its use of terms like paranoia, paranoiac and paranoid; an extreme of loose definition is reached in the work of Meissner (1978).
5. Terms like 'erotomania' and 'paranoid jealousy' are often used to describe symptoms in cases of varying aetiology, only some of which are paranoiac. Delusions of infestation constitute one form of MHP, but Skott (1978) has shown that similar cases can arise in depressive illness, schizophrenia, organic brain disorder, personality disorder and mental subnormality. Although paranoia can occur in a setting of personality disorder or minor brain damage, primary cases should be distinguished from others due to affective illness (Fry, 1978), cerebral atherosclerosis (Turgiyev, 1978) or psychopathy (Pechernikova, 1979). Deafness (Cooper, 1976) or psychosocial stressors like immigration (Binder and Simoes, 1978) and social isolation (Hitch and Rack, 1980) seem to occur in both primary and secondary cases.
6. Many authors fail to differentiate between neurotic and psychotic disorders with rather similar complaints; for example, dysmorphophobia should be, by definition, a non-psychotic illness (Braddock, 1982), but is often used to describe delusions of misshapenness (Hay, 1970). Also, if 'paranoid' really means 'delusional', then a paranoid personality disorder is a contradiction in terms, and it would be better to rename it as perhaps the 'oversensitive' personality disorder (Leonhard, 1976). More care in diagnosis and nomenclature could greatly clarify the definition and classification of paranoid disorders.
7. Paranoia does not usually degenerate into more severe illnesses, but it is chronic, has been incurable, and has thus not been an attractive illness to treat. Psychopathological explanations have been attempted (Freud, 1958; Chalus, 1977), but have not led to effective therapy. Nowadays, MHP is seen to respond well to pimozide (Munro, 1980; Reilly, 1977; Freeman, 1979) and possibly to depot neuroleptics, and there is early evidence that pathological jealousy may also improve with pimozide (Dorian, 1979; Pollock, 1982). The therapeutic picture in paranoia may well be improving.

Paranoia and the paranoid spectrum

A longstanding view, not supported by much actual proof, proposes that paranoia and paranoid schizophrenia are the opposite ends of a continuous spec-



* Including:—erotomania, paranoid jealousy, monosymptomatic hypochondriacal psychosis, delusional grandiosity and litigious paranoia.

[1] Also known as paranoid state, paranoid psychosis, senile paraphrenia, involutional paraphrenia, etc. Not included in DSM III.

[0] Not included as a paranoid disorder in DSM III.

FIG 1.—The paranoid spectrum (hypothesized).

https://doi.org/10.1192/bjp.141.4.344 Published online by Cambridge University Press

trum (Day and Semrad, 1978; Anderson and Trethowan, 1973; Cameron, 1974; Hamilton, 1978). In a minority of cases, paranoia is known to degenerate towards paraphrenia or paranoid schizophrenia (Kolle, 1931; Swanson *et al*, 1970; Munro and Pollock, 1981). A simple diagnostic schema of the paranoid spectrum is proposed in Fig 1.

Kendler (1980b) believes that only the 10 to 20 per cent of paranoia cases which degenerate belong to the spectrum, the remainder forming a separate diagnostic category. To support this, Kendler and Hays (1981) and Watt *et al* (1980) report that there are relatively few cases of schizophrenia in the families of paranoid patients. A relatively weak genetic loading would probably tend to place a case on the paranoia end of the spectrum, while a stronger loading would place it nearer the schizophrenic extreme. The weakest loading might lead to the development of a 'paranoid' personality disorder, but this condition's link with the spectrum is dubious.

Extreme cases of encapsulated, non-degenerative paranoia on one hand, and of paranoid schizophrenia with incoherence, hallucinations and bizarre delusions on the other, are easily distinguished from each other. However, there are intermediate cases which Kraepelin, adapting a term of Kahlbaum, named paraphrenia. Later, it was decided that paraphrenia could not be differentiated from paranoid schizophrenia (Lange, 1926), but many psychiatrists continue to utilize this intermediate category, regarding paraphrenia to paranoid schizophrenia much as hypomania to mania. Paraphrenia is in ICD 9 (297.2), but not in DSM III.

Secondary paranoid conditions occur at any point in the spectrum. A head-injury can produce oversensitive personality features; chronic alcoholism may precipitate pathological jealousy; old age may be associated with the onset of paraphrenia, and amphetamine intoxication can induce an illness identical to paranoid schizophrenia (Connell, 1958). Interestingly, it has been found that MHP cases can respond to pimozide even when an element of affective disorder, organic brain disorder or personality disorder is present (Munro, 1980).

Should paranoia be re-named?

To reduce confusion in nomenclature, Kendler (1980b) has suggested that paranoia be re-named 'simple delusional disorder' (SDD), and he suggests the following criteria for the illness:

1. Onset before age 60;
2. Non-bizarre delusions and/or persistent, pervasive ideas of reference, which have been present for at least two weeks;
3. Absence of persistent hallucinations;
4. Full affective syndrome absent when the patient is delusional;
5. No schizophrenic symptoms, such as prominent thought disorder, etc.;
6. No acute or chronic brain disorder.

If MHP can be accepted as one stereotype of paranoia, some of these factors do not hold. For example, cases with an onset well after 60 have been reported (Riding and Munro, 1975; Munro, 1978); in the early recovery phase, patients may show secondary affective symptoms requiring an antidepressant (Riding and Munro, 1975); some patients with MHP appear to be hallucinated as, for example, when they graphically describe the non-existent 'stench' they claim to emit; the illogic in relation to the delusion resembles thought disorder and, even if encapsulated, it dominates the patient's behaviour; and, as has been remarked (Munro, 1980) a modicum of organic brain disorder is present in some cases. If treatment with pimozide benefits primary and some secondary cases of paranoia, too fine a diagnostic differentiation should be avoided. My findings with MHP bias me against Kendler's term of simple delusional disorder.

Too much can be made of the paranoid spectrum concept and of whether illnesses on it are discrete or form a continuum, but it seems a useful classificatory concept. It is interesting that pimozide, which appears to be uniquely therapeutic in paranoia-type illnesses, is apparently non-unique in the treatment of paraphrenia and paranoid schizophrenia, suggesting a shift in the biochemical basis of the disorders as one moves across the spectrum.

If paranoia is a worthwhile diagnostic category, it requires a name. I suggest that 'paranoia' remains as good a term as any.

Conditions related to paranoia

Folie-à-deux has often been reported in association with paranoid illnesses (Enoch and Trethowan, 1979; Munro, 1980; Skott, 1978). DSM III, renaming it 'shared paranoid disorder' (297.30), insists that it meet the criteria for paranoid disorder, and defines it as a delusional illness, arising from close contact with a person who has established persecutory delusions. The insistence on persecution is unnecessary, and many victims of folie-à-deux are highly impressionable rather than deluded; when separated from the truly deluded individual, they frequently lose their strange beliefs spontaneously. Folie-à-deux should be regarded in a threefold way:

1. As an associated phenomenon of paranoid disorder;

2. As a neurotic or personality-determined disorder, caused by prolonged contact with an individual suffering from delusions;
3. In some cases, especially where the primary and secondary cases share a common hereditary background, as a true delusional illness, shaped by the illness in the primary case.

DSM III also describes acute paranoid disorder (298.30), an illness of less than six months' duration mostly seen in immigrants, refugees and others who have undergone severe environmental disruption. The onset is relatively sudden and the condition rarely becomes chronic. This last point makes it unlikely to be true paranoia, which is always described as chronic and, as Kraepelin believed, paranoia's onset is more usually a gradual one. Acute paranoid disorder is in fact more likely to be a form of psychogenic psychosis (Faergman, 1963; McCabe, 1975) or, if very short-lived, possibly an hysterical psychosis in which ideas of persecution happen to be prominent.

Conclusion

If paranoia were as rare as has been claimed, or as untreatable as it used to be, we could afford to go on neglecting it. However, if its varied presentations are appreciated, it is not so rare, and some of its forms are now amenable to treatment. The condition is prolonged and anguishing, and suicide may sometimes occur (Bebbington, 1976), so that its diagnosis and treatment are not merely matters of academic interest. In addition, since paranoia is a circumscribed and definable disorder, it can be viewed as a kind of naturally occurring model psychosis, and theories of aetiology and treatment may be tested against it. It has been suggested that a relatively specific neurochemical disorder is responsible for MHP and other forms of paranoia (Munro, 1980), with fascinating possibilities for investigation and intervention. Whatever names we give it and its subtypes, it should be emphasized that these illnesses are real, may not be rare, and present a challenge to our diagnostic and therapeutic skills.

Acknowledgements

I am most grateful to Professor J. Hoenig, Head Emeritus of the Department of Psychiatry, Memorial University of Newfoundland, for reading the draft version of this article and for his expert and helpful comments on it.

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Appendix

Working definitions for paranoia and related conditions

Paranoid disorder should be a generic term for delusional illnesses occurring in clear consciousness and not primarily due to underlying physical disorder, depressive illness or organic brain disorder. This would include, among others:

1. *Paranoia:* a permanent and unshakeable delusional system, accompanied by preservation of clear and orderly thinking, volition and behaviour in the rest of the personality. There are several characteristic subtypes:

   (a) *Erotomania* in which the individual has the fixed, erroneous delusion that another person has sexual feelings towards him or her;

   (b) *Pathological jealousy* where the individual has the fixed, erroneous delusion belief that the sexual partner is unfaithful;

   (c) *Monosymptomatic hypochondriacal psychosis (MHP)* in which there is a single, sustained hypochondriacal delusion;

   (d) *Litigious paranoia* in which there is an endless, delusional quest for restitution of a real or imagined wrong;

   (e) *Megalomania* in which there is a delusional preoccupation with one's imagined power, importance or wealth, usually associated with a sense of grandiosity (Kaplan *et al*, 1980).

2. *Secondary paranoid disorder:* a psychotic illness presenting predominantly with delusional symptoms, which appears to result from an underlying physical disorder or another psychiatric illness.

3. *Folie-à-deux* (*shared delusional disorder*): for definition see above.

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