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Are Paranoids Schizophrenics?

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Introduction

This paper reports an investigation in which it was found that, by dividing "paranoids" on a scale of "non-integrated psychosis", two groups were formed which differed significantly from each other on several independent measures. When the same division was made within non-paranoid schizophrenics and within melancholics, very few such differences were disclosed.

The evidence suggests that integrated and non-integrated "paranoids" can usefully be regarded as differentiable groups, the latter being more closely related to other forms of schizophrenia.

It has long been recognized that there is a continuum from Paranoia through Paraphrenia to Paranoid Schizophrenia. What has been in dispute is whether the whole continuum belongs inside, outside or part inside and part outside the class of Schizophrenia. Most authors, regardless of their standpoint on this issue, would agree that those falling very close to the Paranoia end of the continuum are characterized by:

(*a*) Dominant and persistent delusions which are highly systematized and usually involve ideas of persecution and/or grandiosity.

(*b*) A particular type or types of personality which, however, sound like a long-standing, etiolated paranoid psychosis.

(*c*) A relatively later age of onset, at which characteristically different problems are encountered.

(*d*) A relative absence of dementia and of thought disorder.

(*e*) A greater resistance to change, but a better prognosis in the sense that they are more likely to spend a greater proportion of their lives outside of a mental hospital functioning at a socially acceptable level.

Each of the three differing schools can be represented by a distinguished authority. Their views may be summarized as follows:

1. *Kraepelin:* Paranoia is rare and separate from dementia praecox of paranoid type *and* there are in-between states, paraphrenics.
2. *Bleuler:* Pure Paranoia, if it exists at all, is so rare as to be disregardable. Schizophrenia includes in-between states.
3. *Henderson and Gillespie:* Paranoia is separate from Schizophrenia and includes in-between states.

Kraepelin (1915, 1919, 1921), classifying by terminal state, recognized three groups—dementia praecox of paranoid type, paraphrenia and paranoia. Patients in the first group were usually hallucinated as well as deluded. The majority of the remainder were paraphrenics, who showed a better level of personality integration. At the end of this continuum was a small group of Paranoiacs, showing little personality disintegration, highly systematized delusions and an absence of hallucinations. He considered Paranoia to be a distortion rather than a morbid process, a "morbidly transformed expression of natural emotions of the human heart". This he deemed easily understandable in terms of the morbidly self-conscious person resisting the realization of failure at a time of life when youthful optimism has evaporated.

Bleuler (1916) considered that the true Paranoia was a rare case and that a separate class was not warranted. He did, however, note that, where one did occur, the schizophrenic symptoms did not appear unless suspected from the start. The in-between states appeared so frequently, in so many transitional forms, and

"on the other hand a closer study of our cases showed so much that was identical" that he put them all in with Schizophrenia and held that they all manifested a particular sort of disturbance in the associative process.

Henderson and Gillespie (1927–1956) adhered to the school of Kraepelin in regarding Paranoia as a distinct and homogeneous group, characterized by late onset, circumscribed symptomatology and freedom from the gross intellectual and emotional deterioration prevalent in Schizophrenia. They accordingly took the whole Paranoid range, including Paraphrenia and Paranoid Schizophrenia, out of the schizophrenic and into a separate class. This school follows Meyer in believing that "the crux of the situation from the standpoint of differential diagnosis is determined by the underlying type of personality" (Fraser Steele, 1948).

There seems to be most support in the literature for (*i*) widening Schizophrenia to include all paranoid manifestations (other than the neurotic ones, which we regard as extrapunitive but not paranoid) and (*ii*) doing away with the term "Paranoia". In the present study, however, group comparisons between Non-paranoid Schizophrenics, Integrated and Non-integrated Paranoids, show up differences quite clearly.

Procedure

Subjects

The sample with which we are largely concerned in this enquiry consisted of 20 Melancholics, 26 Paranoids and 20 Schizophrenics. All were women between the ages of 20 and 59, who were new, but not always first, admissions.

The Schizophrenics were all acute cases in the sense of having less than two years total hospitalization. The Paranoid group included all cases diagnosed by psychiatrists as Paranoid Psychosis, Paraphrenia or Paranoid Schizophrenia. The Melancholic group included manic-depressives in the depressive phase, involutional melancholics and other psychotic depressives.

Approximately 10 per cent. of all successive psychotic admissions had to be rejected either because they were unwilling or unable to co-operate, or because of organic complications, or because their Mill Hill Vocabulary score fell below the 15th centile.

Measures

All subjects completed the following scales:

The Runwell Symptom-Sign Inventory—RSSI (Foulds, 1962).

The Hysteroid-Obsessoid Questionnaire—HOQ (Martin and Caine, 1963).

The Punitive Scales (Foulds, Caine and Creasy, 1960).

From the RSSI the following scales have been used:

Personal Illness *v.* Normal (PI *v.* No.).
Psychotic *v.* Neurotic (P. *v.* N), 3.
Non-integrated *v.* Integrated Psychotic (NIP *v.* IP), 3.
Paranoid *v.* Schizophrenic (P *v.* S), 5.
Melancholic *v.* Schizophrenic (M *v.* S), 4.
Paranoid *v.* Melancholic (P *v.* M), 16.
Anxiety *v.* Hysteria (A. *v.* H), 4.
Anxiety *v.* Depression (A. *v.* D), 5.
Hysteria *v.* Depression (H *v.* D), 5.

From the Punitive Scales the 3 Extrapunitive (E) measures used were:

Acting-out Hostility (AH), 1.
Criticism of Others (CO), 1.
Delusional Hostility (DH), 1.

and the 2 Intropunitive (I) measures were:

Self-Criticism (SC), 1.
Delusional Guilt (DG), 1.
General Punitiveness (E+I).
Direction of Punitiveness (E−I), 13.

Finally, the Hysteroid score from the HOQ.

The numbers refer to constants added to get rid of minuses.

Since the first three scales on the RSSI above were not described in the original publication and since the NIP *v.* IP Scale is pivotal in this study, they require some further discussion.

The NIP v. *IP Scale* was constructed by selecting those items from the RSSI given significantly more frequently by Non-paranoid Schizophrenics than by Melancholics and by the whole range of Paranoid cases and sub-

tracting the score on items given significantly more frequently by Melancholics or Paranoids, but where the paranoid group was close in frequency to the Melancholic, or conversely.

Since the relevant items for the Integrated Psychotics were mainly delusional items and since Paranoids, Melancholics and Manics probably differ in having predominantly extra-, intro- and im-punitive delusions respectively, one of each type of delusion was matched up so that one point was given for the presence of any one of the three matched items.

Strictly, the scale measures the presence of non-paranoid schizophrenic symptoms. The use of the term "non-integrated" is based on (*a*) common agreement that this distinguishes schizophrenia from melancholia and paranoia; (*b*) the content of the scale itself (see Appendix). An independent validation test for "non-integration" as such has not as yet been carried out; but its absence does not affect the results of this investigation.

Seventy-four per cent. of the original sample of 65 psychotics were allocated in agreement with the psychiatric diagnosis. In the present sample agreement dropped to 62 per cent. Whilst this figure is rather low, it does beg the whole question of the investigation since for this purpose the entire range of Paranoid cases was included in the Integrated Psychotic group.

The P v. *N and the PI* v. *No. Scales* were constructed in a similar way to the NIP *v.* IP Scale. In the first, all the groups used in the NIP *v.* IP Scale were compared with Neurotics; in the second, all subjects used in the P *v.* N Scale were compared with a group of Normals (see Appendix).

On the P *v.* N Scale, 73 per cent. were allocated in agreement with the psychiatric diagnosis; 13 per cent. remained uncertain and 14 per cent. were incorrectly allocated.

On the PI *v.* No. Scale the corresponding figures were 86 per cent., 0 and 14.

Results

On the basis of a score of 5 or more being non-integrated and of 4 or less being integrated on the NIP *v.* IP Scale, the groups split at 15 NIP Schizophrenics to 5 IP; 10 NIP Paranoids to 16 IP and 8 NIP Melancholics to 12 IP. The significance of the difference between the means of Paranoids, Schizophrenics and Melancholics was not examined, but only the difference between NIP and IP within these categories.

Within Schizophrenia, there were only two significant differences (5 per cent level) out of the 16 comparisons. Within Melancholia, there were again only two (5 per cent. level); but, within the Paranoid group, there were seven significant differences (one at each of the 5, 2 and 1 per cent. levels and 4 at the 0·1 per cent. level).

It would appear, therefore, that there are four readily distinguishable groups, which we can call Melancholics; Schizophrenics (Non-paranoid); Paranoid Schizophrenics and Paranoiacs. Since the main interest is in the Paranoid continuum and its relationship to Schizophrenia, the Melancholic group can now be discarded. Table I, shows the means for the 16 measures for the 3 remaining groups.

Schizophrenics and Paranoiacs differ significantly on 9 out of the 16 measures, Paranoid Schizophrenics and Paranoiacs on 7 and Paranoid Schizophrenics and other Schizophrenics on only 3, 2 of which were concerned with Paranoia. Paranoid Schizophrenics, therefore, behave much more like Schizophrenics than like Paranoiacs on these measures, which fall into four mutually exclusive categories:

1. *Common features:* The three groups are more or less indistinguishable on the HOQ, being slightly on the obsessoid side as compared with Normals; on Direction of Punitiveness, though with Paranoiacs somewhat more extra-punitive; on Anxiety *v.* Hysteria and Hysteria *v.* Depression; on Melancholia *v.* Schizophrenia, with all groups on the Schizophrenia side; on Delusional Hostility, where they all score high as compared with Normals.

2. *Schizophrenic features:* Schizophrenics and Paranoid Schizophrenics are each significantly higher than Paranoiacs on PI *v.* No.; on Anxiety *v.* Depression; on General Punitiveness; on Acting-out Hostility; on Self-criticism; on Delusional Guilt and almost so on Criticism of Others.

TABLE I

Mean Scores of Schizophrenics, Paranoid Schizophrenics and Paranoiacs

Scale	20 Schizophrenics		10 Paranoid Schizophrenics		16 Paranoiacs		S *v.* PS		PS *v.* P		S *v.* P	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	t	p<	t	p<	t	p<
PI *v.* No ..	8·55	4·38	9·70	4·82	5·31	3·12			2·71	·02	2·43	·05
P *v.* N ..	5·45	1·72	9·00	2·05	6·50	2·60	4·27	·001	2·48	·05		
P *v.* S ..	5·60	1·39	8·00	1·26	8·75	1·89	4·43	·001			5·60	·001
M *v.* S ..	5·35	1·96	5·80	3·88	5·31	1·45						
P *v.* M ..	12·80	2·93	15·60	3·88	17·87	2·31	2·55	·02			6·95	·001
A *v.* H ..	4·70	1·00	4·70	1·10	3·94	1·09						
A *v.* D ..	7·00	2·61	7·40	1·56	5·44	1·00			3·75	·001	2·28	·05
H *v.* D ..	7·05	1·88	7·00	1·38	5·75	1·09						
AH	6·05	2·26	6·80	1·71	4·06	1·71			3·19	·01	2·76	·01
CO	6·60	2·76	6·40	2·37	4·81	2·13					2·07	·05
DH	4·45	2·33	4·40	2·50	4·50	2·23						
SC	8·55	2·64	9·00	1·61	4·69	1·96			5·60	·001	4·74	·001
DG	5·05	2·25	5·50	1·91	2·56	1·54			4·14	·001	3·67	·001
E+I	30·55	7·57	32·10	6·39	20·62	6·42			4·27	·001	4·07	·001
E−I	16·65	7·02	15·80	6·72	19·12	4·81						
HOQ ..	22·45	6·40	22·50	4·76	21·94	5·27						

3. *Paranoid features:* Paranoiacs and Paranoid Schizophrenics are each significantly higher than Schizophrenics on Paranoia *v.* Schizophrenia and on Paranoia *v.* Melancholia.

4. *Paranoid Schizophrenics*, perhaps because they have features of both groups, score higher than the other two groups on the Psychotic *v.* Neurotic Scale.

Thus, Paranoiacs and Paranoid Schizophrenics have in common their diagnosis based largely on the presence of delusions of persecution and of grandiosity. This apart, Paranoid Schizophrenics and other Schizophrenics are alike and different from Paranoiacs, except in so far as they possess the characteristics of the entire group.

Considerable support for these results is found in a study (Trouton and Maxwell, 1956). All their Schizophrenic groups and their Psychotic Depressives are considerably higher on Neuroticism than are the Paranoiacs. Paranoid Schizophrenics score with the other Schizophrenics and not with the Paranoiacs. On Psychoticism, all Schizophrenics are higher than the Psychotic Depressives and the Paranoiacs, with Paranoid Schizophrenics tending to score the highest, as in this present study. The similarity of these results is the more striking in that Trouton and Maxwell worked with questionnaires filled in by psychiatrists; whereas our results derive from the responses of the patients themselves to an inventory.

It is possible, on the basis of the present study, to consider three of the five crucial criteria for differentiation listed above, namely prognosis, age of onset and dominance of systematized delusions.

Prognosis: Patients were rated by psychiatrists for clinical improvement after 5 to 7 weeks in hospital with the following results: Much improved—Schizophrenics, 35 per cent.; Paranoiacs, 19 per cent.; Paranoid Schizophrenics, 40 per cent. We are dealing here not with prognosis in the sense of prediction of the long-term course of the illness, but with short-term change in clinical condition. Fewer Paranoiacs were rated as Much Improved.

Age of Onset: Combining Paranoid Schizophrenics and Paranoiacs, age is significantly related to scores on the NIP *v.* IP Scale ($r = -0{\cdot}488$; $p < {\cdot}01$). Paranoid Schizophrenics were, therefore, more akin to Schizophrenics

(who were, of course, younger) than to Paranoiacs.

Dominance of systematized delusions: If one takes the Delusional Hostility score as a percentage of the General Punitive score, the following figures are obtained: Schizophrenics, 14·6; Paranoid Schizophrenics, 13·7; Paranoiacs, 21·8. Once again Paranoiacs differ from the other two groups. It is, indeed, only on Delusional Hostility, out of the Punitive Scales, that Paranoiacs differ significantly from Normals.

Conclusion

"The paranoid seems to represent an over-reaction to the underlying trend towards disorganization which exists in the psychosis. The hebephrenic gives way to the trend, whereas the paranoid organizes his resources to fight the disruption" (Shakow, 1962). The paranoid does not necessarily become schizophrenic, but may present the same paranoid picture throughout his illness. Those cases, however, in which the disintegration process is too strong for the defences, or in which the patient was immature when the illness set in, may present a mixed picture of paranoid and of schizophrenic features. Kraepelin's Paraphrenics who become more like Schizophrenics should occasion no surprise or alarm to those who reject the disease entity model, since this releases them from the necessity of making a diagnosis on the basis of what may happen in twenty years' time rather than on the present and recently past condition of the patient. Some Paraphrenics may become Paranoid Schizophrenics; but no one who has been Schizophrenic should, or appears to, become a Paranoiac.

The Paranoids who have schizophrenic symptoms can be distinguished from those who do not by virtue of a different symptom picture, a different problem, a different short-term and, probably, a different long-term course. It is, therefore, suggested that a profitable differentiation can be made along the paranoid continuum at a point further removed from "pure" Paranoia than has recently been customary. In other words, it looks as though the acute variety of Kraepelin's Paraphrenics have aligned themselves with the Paranoia rather than with the Schizophrenia group. For the group closer to Paranoia we have retained the term "Paranoia". It may not be "pure" Paranoia; but we do have to live with impurity.

It is clearly of practical importance to determine the status of Paranoid conditions in relation to Schizophrenia. Investigators of Schizophrenia, for example, will turn up different results according to whether they operate within a Kraepelinian, a Bleulerian or a Hendersonian framework. The present results suggest that the Kraepelinian framework may be the most fruitful.

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Appendix

Non-integrated v. *Integrated Psychotic Scale:*

C	7	Are you ever so cheerful that you want to wear lots of gay things, like button-holes, flowers, bright ties, jewellery, etc.?
C	8	When you get bored, do you like to stir up some excitement?
C	9	Do you ever feel so full of energy and ideas that you do not want to go to bed?
E	2	Are you compelled to think over abstract problems again and again until you can't leave them alone?
E	6	Do distressing thoughts about sex or religion come into your mind against your will?

F 2 Do you ever see visions, or people, animals or things around you that other people don't seem to see?
F 3 Do you often wonder who you really are?
F 4 Do you ever have very strange and peculiar experiences?
F 7 Do you ever hear voices without knowing where they come from?
F 9 Do you ever have very strange and peculiar thoughts?
F 10 Is there something unusual about your body, like one side being different from the other and meaning something different?

The score on this scale is the sum of the above minus the sum of:

D 1 Are people talking about you and criticizing you through no fault of your own? OR
D 5 Have you some special power, ability or influence which is not recognized by other people? OR
H 6 Because of things you have done wrong, are people talking about you and criticizing you? AND
G 6 Have you been in poor physical health during most of the past few years?

Psychotic v. *Neurotic Scale:*

Given more frequently by psychotics: C10; D2, 3, 4, 7, 9, 10; F5, 7, 10; H2, 4, 6.
Given more frequently by neurotics: A7; G5.

Personal Illness v. *Normal Scale:*

Given more frequently by the personally ill: A1, 2, 3, 5, 6, 8, 9, 10; B1, 2, 4, 6, 7, 8, 9; F6; G5; H5.
None given more frequently by normals.
(see Foulds, 1962.)

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